Rehabilitation Manual

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Rehabilitation Manual

General Information

Introduction

The Virginia Medicaid Provider Manual describes the role of the provider in the Virginia Medical Assistance Program (Medicaid). To provide a better understanding of the Medicaid Program, this manual explains Medicaid rules, regulations, procedures, and reimbursement and contains information to assist the provider in answering inquiries from Medicaid members.

The manual can also be an effective training and reference tool for provider administrative personnel, since it conveys basic information regarding the Medicaid Program, covered and non-covered services, and billing procedures. Proper use of the manual will result in a reduction of errors in claims filing and, consequently, will facilitate accurate and timely payment.

In addition to the Medicaid Program, other programs administered by the Department of Medical Assistance Services (DMAS) include the Family Access to Medical Insurance Security (FAMIS) program, the State and Local Hospitalization (SLH) program, and the Uninsured Medical Catastrophe Fund. If you have any questions concerning the Medicaid Program or any of the other programs listed above, please contact the provider "HELPLINE" at:

804-786-6273 Richmond Area

1-800-552-8627 All other areas

Program Background

> In 1965, Congress created the Medical Assistance Program as Title XIX of the Social Security Act, which provides for federal grants to the states for their individual Medical
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> Assistance programs. Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965. This enactment is popularly called "Medicaid" but is officially entitled "Grants to States for Medical Assistance Programs." The purpose of Title XIX is to enable the states to provide medical assistance to eligible indigent persons and to help these individuals if their income and resources are insufficient to meet the costs of necessary medical services. Such persons include dependent children, the aged, the blind, the disabled, pregnant women, and needy children.

The Medicaid Program is a jointly administered federal/state program that provides payment for necessary medical services to eligible persons who are unable to pay for such services. Funding for the Program comes from both the federal and state governments. The amount of federal funds for each state is determined by the average per capita income of the state as compared to other states.

Virginia's Medical Assistance Program was authorized by the General Assembly in 1966 and is administered by the Virginia Department of Medical Assistance Services (DMAS). The Code of Federal Regulations allows states flexibility in designing their own medical assistance programs within established guidelines. Virginia Medicaid's goal is to provide health and medical care for the Commonwealth's poor and needy citizens using the health care delivery system already in place within the state. In 2003, the Virginia General Assembly changed the name of the Medicaid program covering most children to FAMIS Plus. The change in name was intended to facilitate a coordinated program for children's health coverage including both the FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus programs. All covered services and administrative processes for children covered by FAMIS Plus remain the same as in Medicaid. While the Virginia Medicaid Program is administered by DMAS, the eligibility determination process is performed by local departments of social services through an interagency agreement with the Virginia Department of Social Services. The *State Plan for Medical Assistance* for administering the Medicaid Program was developed under the guidance of the Advisory Committee on Medicare and Medicaid appointed by the Governor of the Commonwealth of Virginia. The State Plan is maintained through continued guidance from the Board of Medical Assistance Services, which approves amendments to the *State Plan for Medical Assistance* with policy support from the Governor's Advisory Committee on Medicare and Medicaid. Members of the Governor's Advisory Committee and the Board of Medical Assistance Services are appointed by the Governor.

Individuals originally became eligible for Medicaid because of their "categorical" relationship to two federal cash assistance programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, congressional mandates in the late 1980s resulted in dramatic changes in Medicaid eligibility provisions. Now individuals, in additional selected low-income groups, are eligible for Medicaid solely on the relationship of their incomes to the Federal Poverty Guidelines. New Federal Poverty Guidelines are published annually in the *Federal Register* and become effective upon publication.

On June 7, 2018, Governor Northam approved the state budget that expanded eligibility to include the Modified Adjusted Gross Income (MAGI) adult group, also known as the Medicaid Expansion covered group. The MAGI adult group includes adults between the ages of 19 and 64, who are not eligible for or enrolled in Medicare, and who meet income eligibility rules. After receiving the necessary approvals from the Centers for Medicare and Medicaid Services (CMS), DMAS began enrolling individuals in the MAGI adult group on January 1, 2019.

Medicaid is a means-tested program. Applicants' income and other resources must be within program financial standards, and different standards apply to different population groups, with children and pregnant women, the MAGI adult group, and persons who are aged, blind, or disabled. Reference Chapter III of this manual for detailed information on groups eligible for Medicaid.

General Scope of the Program

The Medical Assistance Program (Medicaid) is designed to assist eligible members in securing medical care within the guidelines of specified State and federal regulations. Medicaid provides access to medically necessary services or procedures for eligible members. The determination of medical necessity may be made by the Utilization Review Committee in certain facilities, a peer review organization, DMAS professional staff or DMAS contractors.

Covered Services

The following services are provided, **with limitations** (certain of these limitations are set forth below), by the Virginia Medicaid Program:

- BabyCare - Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.

- Blood glucose monitors and test strips for pregnant women

- Case management services for high-risk pregnant women and children up to age 1

(as defined in the State Plan and subject to certain limitations)

- Christian Science sanatoria services
- Clinical psychology services
- Clinic services
- Community developmental disability services
- Contraceptive supplies, drugs and devices
- Dental services
- Diabetic test strips
- Durable medical equipment and supplies
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) – For individuals under age 21, EPSDT must include the services listed below:
- Screening services, which encompass all of the following services:
    - Comprehensive health and developmental history
    - Comprehensive, unclothed physical exam
    - Appropriate immunizations according to age and health history
    - Laboratory tests (including blood lead screening)

- Health education

- Home health services

- Eyeglasses for all members younger than 21 years of age according to medical necessity

- Hearing services

- Inpatient psychiatric services for members under age 21

- Environmental investigations to determine the source of lead contamination for children with elevated blood lead levels

- Other medically necessary diagnostic and treatment services identified in an EPSDT screening exam, not limited to those covered services included above

- Skilled nursing facilities for persons under 21 years of age

- Transplant procedures as defined in the section “transplant services”

- All states are required to offer EPSDT to all Medicaid-eligible individuals under age 21 to determine any physical and mental defects that they may have and to provide health care, treatment, and other measures to correct or ameliorate the defects or chronic conditions discovered. The services available under EPSDT are not limited to those available in the Medicaid State Plan for Medical Assistance. Services requiring preauthorization under the State Plan for Medical Assistance will continue to require pre-authorization. DMAS reserves the right to utilize medical necessity

criteria for non-State Plan services under EPSDT.

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver services - Individuals who meet the criteria for a nursing facility level of care can be authorized to receive adult day health care, personal care (agency directed or consumer directed) services, Respite Care and Skilled Respite Care services, Personal Emergency Response

System (PERS), Services Facilitation services, Transition Coordination, and Transition services

- Emergency hospital services

- Emergency services for aliens

- Enteral nutrition (EN) - Coverage is limited to circumstances in which the nutritional supplement is the sole source of nutrition except for individuals authorized through the CCC Plus Waiver or through EPSDT, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does NOT include the provision of routine infant formula.

- Extended services for pregnant women, pregnancy-related and postpartum services for 60 days after the pregnancy ends (limitations applicable to all covered services apply to this group as to all other member groups)

- Eye refractions

- Plan First (family planning services) – Medicaid fee-for-service program for men and women who meet the eligibility criteria. Plan First includes coverage of those services necessary to prevent or delay a pregnancy. It shall not include services to

promote pregnancy such as infertility treatments. Family planning does not include counseling about, recommendations for or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removal of intrauterine devices due to infections.

- Federally Qualified Health Center services
- Home and Community-Based Care Waiver services
- Home health services
- Hospice services for individuals certified as terminally ill (defined as having a medical prognosis that life expectancy is six months or less)
- Family and Individual Support Waiver
- Gender dysphoria treatment services
- Inpatient care hospital services
- Inpatient Psychiatric Hospital Services for Individuals under 21 years of age (medically needy are not covered)
- Intensive rehabilitation services
- Intermediate care facility – Individuals with Intellectual Disabilities Services (medically needy members are not covered)

- Laboratory and radiograph services

- Legend and Non-legend drugs are covered with some limitations or exclusions. (See the Pharmacy Manual for specific limitations and requirements)

- Mental health, with limitations, covered under mental health and intellectual disability community services listed below:

- Mental Health:

- Crisis stabilization
- Mental health support
- Assertive community treatment
- Intensive in-home services for children and adolescents
- Therapeutic day treatment for children and adolescents
- Partial hospitalization Program
- Intensive Outpatient Program
- Psychosocial rehabilitation
- Crisis intervention
- Case management

- Substance Use Disorder:

- Residential treatment for pregnant and postpartum women
- Day treatment for pregnant and postpartum women
- Crisis Intervention
- Intensive Outpatient
- Day Treatment
- Case Management
- Opioid Treatment

- Outpatient Treatment

- Community Living Waiver:

- Nurse-midwife services
- Nursing facility services

- Occupational therapy

- "Organ and disease" panel test procedures for blood chemistry tests

- Optometry services

- Outpatient hospital services

- Over-the-counter alternatives to certain classes of legend drugs. Upon a doctor's prescription or order, a pharmacy may provide and Medicaid will cover a drug that no longer requires a prescription to dispense. See the Pharmacy Manual for specific limitations and requirements.

- Papanicolaou smear (Pap) test

- Payment of deductible and coinsurance up to the Medicaid limit less any applicable payments for health care benefits paid in part by Title XVIII (Medicare) for services covered by Medicaid.
- Physician services

- Podiatry services

- Prostate specific antigen (PSA) test (1998)

- Prostheses limited to artificial arms, legs, and the items necessary for attaching the prostheses, which must be pre-authorized by the DMAS central office. Also breast prostheses for any medically necessary reason and ocular prostheses for reason for loss of eyeball regardless of age of the member or the cause of the loss of the eyeball.

- Psychiatric Hospitals for the Aged (65 Years and Older)

- Psychological testing for persons with intellectual disability as part of the evaluation prior to admission to a nursing facility (January 1, 1989)

- Reconstructive surgery - post-mastectomy (1998)

- Rehabilitation services (physical therapy – effective 1969; other rehabilitation services – effective 1986)

- Renal dialysis clinic services

- Routine preventive medical and dental exams and immunizations, sensory and developmental screenings and immunizations are covered for all eligible members under the age of 21

- Routine preventive and wellness services, including annual wellness exams, immunizations, smoking cessation, and nutritional counseling services for the MAGI

Adult (Medicaid Expansion) covered group.

- Rural Health Clinic services
- School-based services
- Services for individuals age 65 and older in institutions for mental diseases
- Specialized nursing facility services
- Speech-language therapy services
- CCC Plus Waiver services - For children and adults who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and require substantial and ongoing skilled nursing care to avert further disability or to sustain their lives. Authorized services include Private Duty Nursing, Private Duty Respite Care services, Personal Care (Adults Only), Assistive Technology, Environmental Modifications and Transition services.
- Telemedicine for selected services.
- Tobacco Cessation screening, counseling and pharmacotherapies.
- Transplant services: kidney and corneal transplants, heart, lung, and liver transplants, without age limits; under EPSDT, liver, heart, lung, small bowel and bone marrow transplants and any other medically necessary transplant procedures that are not experimental or investigational, limited to persons under 21 years of age. Coverage of bone marrow transplants for individuals over 21 years of age is

allowed for a diagnosis of lymphoma or breast cancer, leukemia, or myeloma.

- Transportation services related to medical care

- Treatment Foster Care Case Management

General Exclusions

Payment cannot be made under the Medicaid Program for certain items and services, and Virginia Medicaid will not reimburse providers for these non-covered services. Members have been advised that they may be responsible for payment to providers for non-covered services. Prior to the provision of the service, the provider must advise the member that he or she may be billed for the non-covered service. The provider may not bill the member for missed or broken appointments, which includes transportation services arranged by the member who is not at the pickup point or declines to get into the vehicle when the provider arrives.

Examples of such non-covered services are as follows:

- Abortions, except when the life or health of the mother is substantially endangered

- Acupuncture

- Artificial insemination or in vitro fertilization

- Autopsy examinations

- Cosmetic surgery

- Courtesy calls - visits in which no identifiable medical service was rendered
- Custodial care
- DESI drugs (drugs considered to be less than effective by the Food and Drug Administration)
- Domestic services (except for those approved as part of personal care services or homemaker services under BabyCare or EPSDT)
- Experimental medical or surgical procedures
- Eyeglass services for members age 21 and over
- Fertility Services - Services to promote fertility are not covered. However, if there is a disease of the reproductive system that requires treatment to maintain overall health, the medical procedure will be covered
- Free services - Services provided free to the general public cannot be billed to Medicaid; this exclusion does not apply where items and services are furnished to an indigent individual without charge because of his or her inability to pay, provided the provider, physician, or supplier bills other patients to the extent that they are able to pay
- Items or services covered under a workers' compensation law or other payment sources
- Meals-on-Wheels or similar food service arrangements and domestic housekeeping

services which are unrelated to patient care

- Medical care provided by mail or telephone (not including telemedicine)
- Medical care provided in freestanding psychiatric hospitals except through EPSDT and SUD waiver, or for individuals aged 65 and over
- Personal comfort items
- Physician hospital services for non-covered hospital stays
- Private duty nursing services – Other than for children under an appropriate waiver or EPSDT and adults under the appropriate waiver
- Procedures prohibited by State or federal statute or regulations
- Prostheses (other than limbs, and the items necessary for attaching them, and breast prostheses)
- Psychological testing done for purposes of educational diagnosis or school admission or placement
- Routine foot care
- Screening services: Exceptions: Pap smears, mammograms, and PSA tests consistent with the guidelines published by the American Cancer Society.

- Services determined not to be reasonable and/or medically necessary

- Services to persons age 21 to 65 in mental hospitals
- Sterilizations when the patient is under age 21 or legally incompetent

- Supplies and equipment for personal comfort, such as adult diapers except when provided as durable medical equipment, "Lifecall" systems (except under the EDCD, DD, and Intellectual Disability Waivers), and air cleaners

- Unkept or broken appointments

- Unoccupied nursing facility beds except for therapeutic leave days for nursing facility patients

- Weight loss programs

MEMBER COPAYS

COPAYS ARE THE SAME FOR CATEGORICALLY NEEDY MEMBERS, QUALIFIED MEDICARE BENEFICIARIES (QMBS), AND MEDICALLY NEEDY MEMBERS. COPAYS AND THEIR AMOUNTS ARE EXPLAINED IN CHAPTER III OF THIS MANUAL.

Managed Care Programs

Coverage for the vast majority of Medicaid enrolled individuals is provided through one of the DMAS managed care programs, Medallion 4.0 or Commonwealth Coordinated Care Plus (CCC Plus). Medallion 4.0 and CCC Plus programs contract with the same six managed care organizations (MCOs), and all MCOs offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. For more information on the current health plans, please visit www.dmas.virginia.gov.

Medallion 4.0 serves as the delivery system for children, pregnant women, and individuals in

the MAGI Adult Group who are not determined to be "medically complex." CCC Plus provides a higher acuity of care coordination services and serves as the delivery system that provides coverage for individuals who are aged, blind or disabled, or who are dually eligible for Medicare and Medicaid, or who receive long-term services and supports, or individuals in the MAGI adult group determined to be "medically complex." "Medically complex" is defined as individuals who have complex medical and/or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

Individuals awaiting managed care enrollment will receive coverage through the DMAS feefor-service program for a brief period (approximately 15-45 days) until they are enrolled in managed care. Additionally, some services for managed care enrolled individuals are covered through fee-for-service; these are referred to as managed care carved-out services. Detailed information about managed care-excluded populations and carved out services for Medallion 4.0 and CCC Plus is available on the DMAS website at http://www.dmas.virginia.gov, under Managed Care Benefits.

Once enrolled in managed care, members have up to 90 days to change their plan for any reason. Members also have the ability to change their plan during their annual open enrollment period. Open enrollment varies by population and program. For the MAGI Adult (expansion) population, open enrollment is from November 1 through December 31 each year. For CCC Plus, open enrollment is from October 1through December 18 each year. For Medallion 4.0 open enrollment varies by program region. (See Managed Care Enrollment Broker section below for additional information.)

Managed Care Enrollment Broker (Maximus)

DMAS contracts with an enrollment broker, Maximus, which provides information to help Medallion and CCC Plus members select or change health plans. Members can find out which health plans contract with their primary care provider (PCP) or other provider. Providers should also let their members know which Medicaid health plans they accept. Members may use the following Maximus contact information for the Medallion 4.0 and CCC Plus managed care programs.

- **Medallion 4.0**

  Maximus has designed a mobile app for managed care enrollment for the Medallion 4.0 program. The app is available to download in the Apple App Store and Google Play for both iPhone and Android users.

  To get the free mobile app, search for Virginia Managed Care on the Apple App Store

or Google Play and download. After downloading the app, members will log in using a two-step identification process, Medicaid ID, and social security number, or social security number and date of birth; non-members can log-in as guests.

Similar to the website, the main capabilities of the app allow members to view their profile, compare health plans, enroll in a health plan, change health plans, and search for providers and health plan information. For more information, members can also visit the Medallion 4.0 enrollment website at: https://virginiamanagedcare.com/ or call 1-800-643-2273 or TTY: 1-800-817-6608.

- **CCC Plus**

  Members can visit the enrollment website for the CCC Plus managed care program at https://cccplusva.com/ to view the health plan comparison chart and to choose or change their health plan. Members can also call the CCC Plus Helpline at 1-834374-9159 or TTY 1-800-817-6608 for more information.

MCO Provider Reimbursement

In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for service individuals. For more information, please contact the individual 's managed care plan directly. Providers interested in contracting with the plans should also contact the MCO directly. MCO contact information for contracting and credentialing is available on the DMAS website:

- **Medallion 4.0** The managed care helpline for the Medallion program is 800-6432273 and the web address is https://www.virginiamanagedcare.com/
- **CCC Plus** (http://www.dmas.virginia.gov/#/cccplusinformation See “Medical Provider Update October 2017”)

DMAS reimburses the health plans a monthly capitated fee for each member. These fees are preset, and are determined by demographics such as patient’s age, sex, program designation, and locality of residence. Each MCO is responsible for developing its own network of providers and for ensuring that its delivery system has an adequate number of facilities, locations, and personnel available and accessible to provide covered services for its members. Providers who contract with a MCO must meet the MCO’s contracting requirements.

Medicaid-contracted MCOs must provide all the services covered by Medicaid, at least within an equal, amount, duration, and scope as Medicaid, except for certain "carved-out services." "Carved-out" means that the client remains enrolled in the MCO plan but the carved-out services are covered and reimbursed by DMAS within DMAS program guidelines. **DMAS will NOT provide reimbursement for services provided to MCO enrolled members EXCEPT for those services carved-out specifically from the MCO contracts.** Carved-out services vary by program and are listed in the CCC Plus and Medallion 4.0 Contracts, available on the DMAS Website, in the Managed Care Benefits section. The member must present his or her Medicaid plastic ID card when receiving carved-out services.

Eligibility and MCO Enrollment Verification

Medicaid eligibility and managed care enrollment coverage must be verified before treatment is provided. Medallion and CCC Plus members will have a MCO identification card and a Medicaid card. Medallion and CCC Plus MCO providers must adhere to their contract with the MCO regarding referrals, prior authorization, and billing requirements. Service authorization from the member's MCO is required for any out-of-network services, *except for emergency and family planning services.* The provider is responsible for ensuring that proper referrals and service authorizations are obtained. If the MCO denies authorization for a service, the member may exercise his right to appeal to the MCO. Members can also appeal to DMAS after first exhausting the MCO's appeal process. A provider may bill a member only when the provider has provided advanced written notice to the member, prior to rendering services that their MCO/Medicaid will not pay for the service. The notice must also share that the provider is accepting the member as a private pay patient, not as a Medicaid patient and the services being provided are the financial responsibility of the patient. Failure to confirm Medicaid eligibility and MCO coverage can result in a denial of payment.

To verify eligibility, call the MCO's enrollment verification system or the DMAS MediCall line at 1-800-772-9996 or 1-800-884-9730 (outside of Richmond), or (804) 965-9732 or (804) 965-9733 for Richmond and the surrounding counties. Eligibility information is also available using the web-based Automated Response System (ARS). When using the DMAS MediCall line or the ARS system, MCO information, if applicable, follows Medicaid eligibility information.

Continuity of Care

The Department attempts to make the transition between fee-for-service Medicaid and the MCO seamless whenever possible. As a result there is a process to ensure that the Medicaid information and authorization information is transferred and honored. In order to assure continuity of care for members enrolled in MCOs, the following procedures are used:

- The Member's MCO shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the MCO enrollment effective date, in the absence of a written agreement otherwise. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the member's MCO shall continue authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider;
- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of dis-enrollment to the feefor-service system, if the member otherwise remains eligible for the service(s), and if the provider is a Medicaid provider;
- If the prior authorized service is an inpatient stay, the claim should be handled as follows: o If the provider contracts with the MCO under a per diem payment methodology, the financial responsibility shall be allocated between the member's current MCO and either DMAS or the new MCO. In the absence

  of a written agreement otherwise, the member's current MCO and DMAS or the new MCO shall each pay for the period during which the member is enrolled with the entity.

  o If the provider contracts with the MCO under a DRG payment methodology, the MCO is responsible for the full inpatient hospitalization from admission to discharge, including any outlier charges.

- If services have been authorized using a provider who is out of network, the member's MCO may elect to reauthorize (but not deny) those services using an in-network provider.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the

provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;
  - Assistive technology
  - Blood lead testing
- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:
  - Intensive in-home services
  - Therapeutic day treatment
- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations

- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a

physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	**Co-pay Status 1**	**Co-pay Status 2**
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

EMERGENCY MEDICAID SERVICES FOR ALIENS

Section 1903v of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for specified aliens when these services are provided in a hospital emergency room or inpatient hospital setting. (See Chapter III for details on eligibility.)

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks
- Traumatic injuries
- Childbirth
- Acute coronary difficulties
- Emergency surgeries (i.e., appendectomies)
- Episodes of acute pain (etiology unknown)
- Acute infectious processes requiring intravenous antibiotics
- Fractures

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care
- Physician services
- Inpatient hospitalization not to exceed limits established for other Medicaid members
- Ambulance service to the emergency room or hospital
- Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are not included in the covered services.

Client Medical Management (CMM)

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 431.54(e-f) and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC

30-130-820. (See the “Exhibits” section at the end of this chapter for detailed information on the CMM Program.)

Providers may refer Medicaid patients suspected of inappropriately using or abusing

Medicaid services to DMAS's Recipient Monitoring Unit. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program.

Referrals may be made by telephone or in writing. The number for the Recipient Monitoring

Unit is (804) 786-6548 or toll-free (888) 323-0589. Referrals can also be faxed to (804) 3718891. Office hours are 8:15 a.m. – 5:00 p.m., Monday through Friday except state holidays. Voice mail receives after-hours referrals.

Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

When making a referral, provide the member's name and Medicaid number and a brief statement regarding the nature of the utilization problems. Copies of pertinent documentation, such as emergency records, would be helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Sources of Information

MediCall Automated Voice Response System

Toll-free numbers are available 24-hours-per-day, seven days a week, to confirm member

eligibility status, claim status and check status. The numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification. Specific instructions on the use of the verification systems are included in “Exhibits” at the end of this chapter.

Automated Response System (ARS)

Providers may use the Internet to verify member eligibility and perform other inquiry functions. Inquiries can be submitted in real-time. Specific instructions on the use of the ARS are included in “Exhibits” at the end of this chapter.

HELPLINE

A toll-free "HELPLINE" is available to assist providers in interpreting Medicaid policy and procedures and in resolving problems with individual claims. The HELPLINE numbers are:

- (804)786-6273 Richmond Area & out-of-state long distance
- 1-800-552-8627 In-state long distance (toll free)

The HELPLINE is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays.

The Virginia Medicaid provider number must accompany all provider inquiries (both written and via the HELPLINE). All provider information and data are filed by provider number. This number will expedite recovery of the requested information.

Do not use these HELPLINE numbers for member eligibility verification and eligibility questions. Local departments of social services are responsible for supplying information to members, and members who have questions about the Medicaid Program should be directed to their local departments of social services. If MediCall is not available, the data will also be unavailable to the HELPLINE (when the system is down).

The Medicaid HELPLINE and MediCall numbers are for provider use only and should not be given to members.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

The Virginia MMIS will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response.

Although not mandated by HIPAA, DMAS has opted to produce an unsolicited 277 transaction to report information on pended claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Provider Manual Updates

This manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, revised pages or sections will be issued by the Department of Medical Assistance Services (DMAS) as needed.

Notice of Provider Responsibility

The provider is responsible for reading and adhering to the policies and regulations explained in this manual and for ensuring that all employees do likewise. The provider also certifies by his or her personal signature or the signature of an authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Satisfaction and payment of any claim will be from federal and State funds, and any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or State laws.

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

The Virginia Medical Assistance MediCall System offers Medicaid providers twenty-four hour-a-day, seven-day-a-week access to current member eligibility information, check status, claims status, prior authorization information, service limit information, pharmacy prescriber identification number cross reference, and information to access member eligibility and provider payment verification via the Internet. MediCall is an enhancement to the previous Medicaid Audio Verification Response System (AVRS).

Not only does MediCall offer providers flexibility in choosing the time of day for their inquiries, but it also makes efficient use of staff time. A valid provider number and a touchtone telephone are required to access MediCall.

To reach an operator while using the member eligibility verification feature of MediCall, key

“0” at any prompt within the Member Eligibility menu. Operator assisted calls are limited to three name searches per call. The operator will not be able to return the caller to MediCall for further inquiries. Operators are available from 8:30 a.m. to 4:30 p.m. Eastern time, Monday through Friday except for state holidays.

MediCall prompts the caller throughout the inquiry, giving and receiving only essential,

pertinent information. The data provided is the most up-to-date information available, direct from the Medicaid eligibility, claims and remittance databases. If the caller waits too long to respond to a system prompt, the call will be disconnected.

System downtime will be scheduled during non-peak hours. If the caller dials MediCall during this time, the caller will be informed that the system is unavailable. System downtime is typically scheduled for:

2:00 a.m. to 4:00 a.m. Daily 2:00 a.m. to 6:30 a.m. Thursday

10:00 p.m. Saturday to 6:00 a.m. Sunday

The telephone numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

If you have any questions regarding the use of MediCall, contact the Medicaid Provider "HELPLINE." The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The HELPLINE numbers are:

1-804-786-6273 Richmond Area and out of state long distance

In state long distance (toll-free) 1-800-552-8627

HOW TO USE THE SYSTEM

To access MediCall, the provider must have a currently active Medicaid provider number. The provider's number is verified before access to MediCall is authorized.

Responses by the caller to MediCall are required within a specified period of time. If the time limit is exceeded, the call will be disconnected. The caller should have the following information available before calling:

- 10 digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Member Medicaid Number (12 digits) or Social Security Number (9 digits) **and**

  Date of Birth (8 digits) in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status)
- From and Thru Date(s) of Service in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status). The caller will have the following limits when entering dates of service:
- The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the # key prompts the system to continue.
- Future month information is only available in the last week of the current month.
- Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

After dialing the MediCall number, the system will ask for the NPI or API. Enter the 10 digit number and select from the following options:

- Press “1” for member eligibility verification.

- Press “2” for claims status.
- Press “3” for recent check amounts.
- Press “4” for service authorization information.
- Press “5” for service limit information.

MEMBER ELIGIBILITY VERIFICATION

Enter the From and Thru dates of service. **The service dates for member eligibility verification cannot span more than 31 days.** When the dates of service have been entered, MediCall will verify the information and respond by speaking the first six letters of the last name and the member's Medicaid number for confirmation.

Remain on the line to obtain important member information that might affect payment, such as:

- Special Indicator Codes (Copayment)
- Client Medical Management Information Including Pharmacy/Physician Telephone Number
- Medicare Eligibility
- Other Insurance Coverage

- Special Coverage (QMB, QMB--Extended)
- "MEDALLION" Participation (prior to July, 2012)
- Managed Care Organization provider name and assignment dates

At this point, MediCall will prompt the caller for the next action. The caller may ask for additional dates of service on this member, or may inquire on another member.

The caller may check up to **three** dates of service for each member and inquire on up to **three** members per call.

If the caller is using a Social Security Number instead of the member ID number, the dates of service will relate to the first member ID reported. If multiple open records exist for the same Social Security Number, you will be advised to contact the local department of social services. You will be given a 3-digit city/county code of the appropriate agency and a 5-digit caseworker code. A cross-reference list of the city/county codes is provided as an exhibit to this chapter.

The caller will receive a "not eligible" response if the future dates about which he or she inquires are beyond the information on file.

A response, "not eligible," will be given if the member is not eligible for all days within the time span entered.

PROVIDER CHECK LOG

The most recent check information is presented by invoice type. This inquiry permits the provider to receive check dates and amounts from the most recent three remittances.

CLAIMS STATUS

For claims status information, the MediCall system will prompt the provider to choose the among the following invoice types (additional information in italics).

- For inpatient care, press 01.
- For long-term care, press 02.
- For outpatient hospital, home health or rehabilitation services, press 03.
- For personal care, press 04.
- For practitioner (physician CMS-1500 billing), press 05.
- For pharmacy, press 06.
- For independent labs (outpatient lab services), press 08.
- For Medicare crossover, press 09.
- For dental, press 11.
- For transportation, press 13.

For claims status, the From date cannot be more than 365 days in the past. The Thru date cannot be more than 31 days later than the From date. After keying the member identification number and the From and Thru date(s) of service, MediCall will provide the status of each claim up to and including five claims. MediCall will prompt for any additional claims or return to the main menu.

SERVICE AUTHORIZATION INFORMATION

The From and Thru dates for prior authorization cannot span more than 365 days. When the 12-digit member ID number and the 8-digit from and through dates of service have been entered, you will be prompted to enter the 11-digit prior authorization number, if known. If you do not know the prior authorization number, then press the pound (#) key. MediCall will verify prior authorization data on file. The system will prompt you to return additional prior authorization data for the same member and dates, enter new dates for the same member, another prior authorization number for the same member or to enter another member ID number to begin a new inquiry.

SERVICE LIMITS INFORMATION

Service limits can be obtained by service type or procedure code:

- For occupational therapy, press 1. For physical therapy, press 2 For speech therapy, press 3.
- For home health aide, press 4.
- For home health skilled nursing, press 5.
- For DME purchases, press 6 and for DME rentals, press 7.

For occupational therapy, speech therapy or physical therapy the MediCall system will return non-school based and school based service limits separately.

PRESCRIBING PROVIDER ID

Only enrolled Pharmacy providers can access this choice. When prompted, the caller should enter the license number of the prescriber. MediCall will return the first six letters of the prescriber’s last name and Medical Assistance provider number. If the prescriber is not

active in Virginia Medicaid, you will receive a message that the number is not on file.

The Automated Response System (ARS)

GENERAL INFORMATION

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-fourhour-a-day, seven-day-a week Internet access to current member eligibility information, service limits, claim status, service authorizations, and provider payment history. This weenabled tool helps provide cost-effective care for members, and allows providers to access current information quickly and conveniently.

The ARS can be accessed through the Virginia Medicaid Web portal at www.virginiamedicaid.dmas.virginia.gov. Please visit the portal for information on registration and use of the ARS.

CITY/COUNTY CODES

(The Three-Digit Numerical Identifier of the Local Social Services/Welfare Agency Currently Handling the Case)

If two or more member records using the same SSN are active on the same date of service, inquirers are prompted to contact the Social Services agency for resolution.

COUNTIES

001	Accomack	049	Cumberland	097	King and Queen
003	Albermarle	051	Dickenson	099	King George
005	Alleghany	053	Dinwiddie	101	King William
007	Amelia	057	Essex	103	Lancaster
009	Amherst	059	Fairfax	105	Lee
011	Appomattox	061	Fauquier	107	Loudoun
013	Arlington	063	Floyd	109	Louisa
015	Augusta	065	Fluvanna	111	Luneburg
017	Bath	067	Franklin	113	Madison
019	Bedford	069	Frederick	115	Mathews
021	Bland	071	Giles	117	Mecklenburg

023	Botetourt	073	Gloucester	119	Middlesex
025	Brunswick	075	Goochland	121	Montgomery
027	Buchanan	077	Grayson	125	Nelson
029	Buckingham	079	Greene	127	New Kent
031	Campbell	081	Greensville	131	Northampton
033	Caroline	083	Halifax	135	Nottoway
035	Carroll	085	Hanover	137	Orange
037	Charlotte	087	Henrico	139	Page
041	Chesterfield	089	Henry	141	Patrick
043	Clarke	091	Highland	143	Pittsylvania
045	Craig	093	Isle of Wight	145	Powhatan
047	Culpeper	095	James City	147	Prince Edward
149	Prince George	167	Russell	179	Stafford
153	Prince William	169	Scott	181	Surry
155	Pulaski	171	Shenandoah	183	Sussex
157	Rappahannock	173	Smyth	185	Tazewell
159	Richmond	175	Southampton	187	Warren
161	Roanoke	177	Spotsylvania	191	Washington
193	Westmoreland	195	Wise	197	Wythe
199	York				

CITIES

510	Alexandria	620	Franklin	710	Norfolk
515	Bedford	630	Fredericksburg	720	Norton
520	Bristol	640	Galax	730	Petersburg
530	Buena Vista	650	Hampton	735	Poquoson
540	Charlottesville	660	Harrisonburg	740	Portsmouth
550	Chesapeake	670	Hopewell	750	Radford
570	Colonial Heights	678	Lexington	760	Richmond
580	Covington	680	Lynchburg	770	Roanoke
590	Danville	683	Manassas	775	Salem
595	Emporia	685	Manassas Park	780	South Boston
600	Fairfax	690	Martinsville	790	Staunton
610	Falls Church	700	Newport News	800	Suffolk
810	Virginia Beach	820	Waynesboro	830	Williamsburg
840	Winchester				

976 Central Processing Unit for FAMIS

STATE MENTAL HEALTH FACILITIES

983 Southern Virginia Mental Health Institute

985. Southeastern State Hospital
986. Northern Virginia Training Center
987. Virginia Treatment Center
988. Northern Virginia Mental Health Institute

990. Central Virginia Training Center
991. Western State Hospital
992. Southwestern State Hospital
993. Piedmont State Hospital
994. Eastern State Hospital

996. Hiram Davis Hospital
997. Catawba State Hospital

CLIENT MEDICAL MANAGEMENT INTRODUCTION

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 456.3 and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30130-810.

MEMBER RESTRICTION

Utilization Review and Case Management

Federal regulations allow states to restrict members to designated providers when the members have utilized services at a frequency or amount that is not medically necessary.

Restricted members are identified and managed by the Recipient Monitoring Unit (RMU) in the Division of Program Integrity.

CMM enrollment is based upon review of the individual member's utilization patterns. All Medicaid members except MCO members and institutionalized long-term care residents are eligible for utilization review by RMU staff. If the member's utilization patterns meet the criteria for enrollment in CMM, the member is notified to select designated primary providers. Examples of inappropriate utilization are:

- Emergency room use for medical problems that could be treated in a physician's office;
- Using more than one physician and/or pharmacy to receive the same or similar medical treatment or prescriptions; and
- A pattern of non-compliance which is inconsistent with sound fiscal or medical practices.

Each CMM member is assigned a case manager in the Recipient Monitoring Unit to assist both members and providers with problems and questions related to CMM. The case manager is available to:

- Resolve case problems related to CMM procedures and provider assignments;
- Counsel the member on the appropriate access to healthcare;
- Approve/deny requests for provider changes; and
- Complete a utilization review prior to the end of the enrollment period to determine if CMM restriction should be extended.

Member Enrollment Procedures

Members identified for CMM enrollment receive a letter explaining the member/provider relationships under medical management. The letter includes the Member/Primary Provider Agreement forms (see the sample forms at the end of this section) with directions for completing and returning the form to the Recipient Monitoring Unit. Members are given thirty (30) days to select their primary providers by obtaining their signatures on the form.

The provider's signature indicates agreement to participate as the CMM provider for the member. DMAS reviews member requests for specific providers for appropriateness and to ensure member accessibility to all required medical services.

Members also have thirty (30) days from the receipt of the restriction notice to appeal enrollment in CMM. Assignment to designated providers is not implemented during the appeal process.

CMM enrollment is for 24 months. Assignment to both a physician and pharmacy is made with few exceptions.

When members do not return choices to the Recipient Monitoring Unit or have difficulty in finding providers, RMU staff will select providers for them. RMU staff contact providers directly to request participation as a CMM provider for the member and follow-up by mailing or faxing the agreement form for the provider's signature.

When completed agreement forms are received, the member is enrolled in CMM effective the first of the next month in which a restricted Medicaid card can be generated. Both members and selected providers are notified by mail of the enrollment date.

Members enrolled in the Client Medical Management can be identified through the process of eligibility verification. A swipe of the Medicaid ID card will return the names and telephone numbers of the primary care physician and designated pharmacy. The dates of assignment to each provider are also included. This information is also available through the MediCall System and the web-based Automated Response System (ARS). Instructions for both resources are provided in this chapter.

Each CMM member also receives an individual Medicaid coverage letter with the name(s) and address of the designated primary health care provider and/or designated pharmacy printed on the front each time there is a change in providers.

Designated Primary Care Physicians (PCP)

Any physician enrolled in Medicaid as an individual practitioner may serve as a designated primary care physician (PCP) except when:

- The physician's practice is limited to the delivery of emergency room services; or
- The physician has been notified by DMAS that he or she may not serve as a designated provider, covering provider, or referral provider for restricted members.

Federally Qualified Community Health Centers (FQHCs) and Rural Health Clinics (RHCs) may serve as PCPs also. Other provider types such as ambulatory care centers may be established as designated providers as needed but only with the approval of DMAS.

Primary care physicians are responsible for coordinating routine medical care and making referrals to specialists as necessary. The PCP must arrange 24-hour coverage when they are not available and explain to their assigned members all procedures to follow when the office is closed or when there is an urgent or emergency situation.

The provider's *NPI number* is used for billing and referral purposes.

Designated Pharmacies

Any pharmacy enrolled as a community pharmacy billing on the Pharmacy Claim Form or other acceptable media may serve as a designated pharmacy unless the pharmacy has been notified by DMAS that it may not serve as a designated provider.

Designated pharmacies must monitor the member's drug regimen. The pharmacist should fill prescriptions from the PCP, referred physicians, and emergency prescriptions. Referrals can be confirmed by reviewing the member's copy of the referral form or by contacting the

PCP's office. Close coordination between the PCP and the pharmacist, particularly if a medication problem has been identified, is a very important component of the program.

Changing Designated CMM Providers

The member or designated provider may initiate a request for a change of a designated provider by contacting the Recipient Monitoring Unit. Designated providers requesting a change must notify the member in addition to contacting RMU. If the designated provider requests the change and the member does not select a new provider by the established deadline, RMU shall select for them.

All changes must be preauthorized by DMAS RMU staff. The member's RMU case manager may contact the provider before making a final decision on the change request to try to resolve questions or issues and avoid unnecessary changes. If DMAS denies a member's request, the member shall be notified in writing and given the right to appeal the decision. Changes are allowed for:

1. Relocation of the member or provider;
2. Inability of the designated provider to meet the routine medical/pharmaceutical needs of the member; or
3. Breakdown of the relationship between the provider and member.

Provider changes can occur any time of the month because the effective date is the date the new provider signs the Member/Primary Provider Agreement form. When a new provider is assigned, RMU mails a letter to the member confirming the effective date of the change. The letter instructs the member *to show the letter with the Medicaid identification card*. Letters go to the affected providers also. All verification inquiries will return the new primary provider from the date it is entered into the computer system.

A PCP No Longer in Practice

If a provider leaves the practice or retires, he or she must notify CMM so that the restricted member can be reassigned to a new PCP.

Covered Services and Limitations

Under CMM, DMAS will pay for covered outpatient medical and/or pharmaceutical services only when they are provided (1) by the designated providers, (2) by physicians seen on written referral from the PCP, (3) by covering providers linked with the designated provider in a CMM Affiliation Group, or (4) in a medical emergency. A medical emergency means that a delay in obtaining treatment may cause death or serious impairment of the health of the member. Payment for covered outpatient services will be denied in all other instances (unless the covered services are excluded from Client Medical Management Program requirements), and the member may be billed for the services.

All services should be coordinated with the designated provider. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

Physician Services

A Medicaid-enrolled physician who is not the PCP may provide and be paid for outpatient services to these members only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the member.

- On written referral from the PCP using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.

- When they are a part of a CMM provider affiliation group that includes the PCP.

- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

Services Excluded from PCP Referral

These services should be coordinated with the primary health care provider whose name appears on the member's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program.

Covered services that do not need a referral include:

- Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) wellchild exams and screenings (members under age 21);

- Immunizations (member under age 21);

- Family planning services;

- Expanded prenatal services, including prenatal group education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants;

- Dental services (members under age 21);

- Services provided under Home and Community-Based Care Waivered Services;
- Hospice services;
- Renal dialysis services;
- Routine vision care services (routine diagnostic exams for members of all ages and eyeglasses for members under age 21). Medical treatment for diseases of the eye and its appendages still requires a written referral;
- Audiology services;
- Podiatry services;
- Prosthetic services;
- MH/ID community rehabilitative services;
- Psychiatric diagnostic and therapeutic services (limited sessions of outpatient treatment);
- Inpatient hospital services;
- Life-threatening medical emergencies; and

- School-based services.

CMM Provider Affiliation Groups

Physician affiliation groups allow covering physicians to see each other's patients without a written referral. CMM affiliations may be set up for physicians within a practice or for the single practitioner who arranges coverage by a physician not sharing office space. Affiliations can be open-ended or for a specified period of time (such as when the PCP is away from the office for days or weeks). CMM affiliations may include physicians, Rural Health Clinics, Federally Qualified Health Clinics (FQHC), and nurse practitioners.

Affiliations are not member-specific. This means that once provider numbers are affiliated, claims will pay for all CMM members who receive services from a member of an affiliation group that includes the member's PCP on the date of service.

The PCP requests affiliation by completing the CMM Provider Affiliation Form (see sample form at the end of this section) and returning it to the Recipient Monitoring Unit (RMU). The form is used to set up a new affiliation group or to update a group. Providers are responsible for notifying DMAS when a new provider joins the group or a provider leaves the group to ensure claims are processed correctly. Contact the Recipient Monitoring Unit at (804) 786-6548 in Richmond, or toll-free at 1-888-323-0589, to request a form.

Emergency Room Services

Outpatient hospital emergency room services for restricted members are limited to reimbursement for medical emergencies. Emergency hospital services means that the threat to the life or health of the member necessitates the use of the most accessible hospital facility available that is equipped to furnish the services. Reimbursement may be conditional upon the review of the emergency-related diagnosis or trauma ICD diagnosis codes and the necessary documentation supporting the need for emergency services. Additional guidelines for payment of medical services provided in the outpatient hospital emergency room setting are listed in Chapter IV "Covered Services" in this manual.

CMM clients must have a written PCP referral in order for non-emergency services provided in the emergency room to be reimbursed at an all-inclusive rate. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become non-covered services, and the member is responsible for the full cost of the emergency room visit.

CMM also requires a PCP referral form for:

- Reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting, and
- Reimbursement for any follow-up outpatient or office consultations resulting from an ER visit.

Emergency Pharmacy Services

Prescriptions may be filled by a non-designated pharmacy only in emergency situations (e.g., insulin or cardiac medications) when the designated pharmacy is closed or the designated pharmacy does not stock or is unable to obtain the drug.

Provider Reimbursement and Billing Instructions

Management Fees

Each physician, FQHC, or Rural Health Clinic that serves as a CMM primary care provider (PCP) receives a monthly case management fee of $5.00 for each assigned CMM member. Payment is made through a monthly remittance process. PCPs receive a monthly report listing the CMM members assigned the previous month for whom payment is made.

PCP and Designated Pharmacy Providers

DMAS pays for services rendered to CMM members through the existing fee-for-service

methodology. Designated providers (PCP's and pharmacies) bill Medicaid in the usual manner, but non-designated providers who are not affiliated with the CMM provider must follow special billing instructions. Complete instructions for the CMS 1500 (08-05) and UB-04 billing invoices as well as Point-of-Sale (POS) billing can be found in the billing instruction chapter of this manual.

Affiliated Providers

Providers who are affiliated with a designated CMM provider in the Medicaid system bill Medicaid in the usual manner with no special billing instructions. Claims process with a look-up to the CMM Affiliation Groups in the system.

Referral Providers

To receive payment for their services, referral providers authorized by the client's PCP to provide treatment to that client must place the Provider Identification Number of the PCP in Locator 17a (1D qualifier followed by the API number) or 17b (National Provider Identifier number of referring physician – 17B requirement effective 5/23/08) of the CMS-1500 (0805) and attach the Practitioner Referral Form.

Physicians Billing Emergency Room Services

When billing for emergency room services on the CMS-1500, the attending physician bills evaluation and management services with CPT codes 99281-99285 and enters "Y" in Block 24-C. When the PCP has referred the client to the emergency room, place the PCP's NPI number in Block 17b on the CMS -1500 and attach the Practitioner Referral form.

Facilities Billing Emergency Room Services with a Referral

When billing for emergency room services on the on the UB-04 CMS 14-50, place the PCP's provider number in space 78, and attach the Practitioner Referral Form.

Non-designated Pharmacy Providers

When billing on the Pharmacy Claim Form or as a Point-Of-Sale (POS) provider, enter code

"03" in the "Level of Service" field to indicate emergency.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate members on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the member and a brief statement about the nature of the utilization problems. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

PROVIDER RESTRICTION

Restricted providers are identified and managed by the DMAS Provider Review Unit. States may restrict providers from participation in the Medicaid Program when the provider has provided items or services at a frequency or amount not medically necessary or has provided items or services of a quality that does not meet professionally recognized standards of health care. State regulations allow DMAS to restrict providers' participation as designated providers, referral providers, or covering providers for CMM restricted members when a provider has billed services at a frequency or level exceeding that which is medically necessary or when a provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.

Provider restriction is for 24 months. Providers may appeal any proposed restriction in accordance with the *Code of Virginia*, Section 2.2-4000 et seq., as discussed in the chapter containing utilization review and control information in this manual. Restriction is not implemented pending the result of a timely appeal request.

Provider Participation Requirements (Rehab)

Managed Care Enrolled Members

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted Managed Care Organizations (MCOs) and their network of providers. All providers must check eligibility (Refer to Chapter 3) prior to rendering services to confirm which MCO the individual is enrolled. The MCO may require a referral or prior authorization for the member to receive services. All providers are responsible for adhering to this manual, their

provider contract with the MCOs, and state and federal regulations.

Even if the individual is enrolled with an MCO, some of the services may continue to be covered by Medicaid Fee-for-Service. Providers must follow the Fee-for-Service rules in these instances where services are "carved out." The carved-out services vary by managed care program. For example, where one program (Medallion 3.0) carves out Early Intervention, the CCC Plus program has this service as the responsibility of the MCO. Refer to each program's website for detailed information and the latest updates.

There are several different managed care programs (Medallion 3.0, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE) for Medicaid individuals. DMAS has different MCOs participating in these programs. For providers to participate with one of the DMAS-contracted managed care organizations/programs, they must be credentialed by the MCO and contracted in the MCO's network. The credentialing process can take approximately three (3) months to complete. Go to the websites below to find which MCOs participate in each managed care program in your area:

Ø Medallion 3.0:

http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx

Ø Commonwealth Coordinated Care (CCC):
http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx

Ø Commonwealth Coordinated Care Plus (CCC Plus):
http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx

Ø Program of All-Inclusive Care for the Elderly (PACE):
http://www.dmas.virginia.gov/Content_atchs/ltc/WEB%20PAGE%20FOR%20PACE%20Sites%20in%20VA.pdf

At this time, individuals enrolled in the three HCBS waivers that specifically serve individuals with intellectual and developmental disabilities (DD) (the Building Independence (BI) Waiver, the Community Living (CL) Waiver, and the Family and Individual Supports (FIS) Waiver) will be enrolled in CCC Plus for their non-waiver services only; the individual's DD waiver services will continue to be covered through the Medicaid fee-for-service program.

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, MCO enrollment, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

Participating Provider (Rehab)

A participating provider is an institution, facility, agency, person, partnership, corporation, or association that is certified by the Centers for Medicare and Medicaid Services (CMS) and has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

Requests for Enrollment

All providers who wish to participate with Virginia Medicaid are being directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov.

If you have any questions regarding the online or paper enrollment process, please contact the Provider Enrollment Services at toll free 1-888-829-5373 or local 1-804-270-5105.

Provider Screening Requirements

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as “limited”, “moderate” or “high”. Please refer to the table at the end of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment

criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the "high" level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process. **The application fee requirements are also outlined in Appendix section of this provider manual.**

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied.

An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously

mentioned above, then the application will be rejected.

Revalidation Requirements

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via our web portal.

Registration into the Virginia Medicaid Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

Ordering, Referring, and Prescribing (ORP) Providers

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

Please go to Chapter V of this provider manual to review the new billing procedures related to the implementation of these new screening requirements.

Participation Requirements (Rehab)

Providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify Xerox-Provider Enrollment Services Unit, in writing, of any change in the information which the provider previously submitted to Xerox- Provider Enrollment Services Unit.
- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed.
- Ensure the recipient's freedom to reject medical care and treatment.
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.
- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public.
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.
- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the patient or any other party.
- Accept Medicaid payment from the first day of eligibility if the provider was aware that application for Medicaid eligibility was pending at the time of admission.

- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered.
- Accept assignment of Medicare benefits for eligible Medicaid recipients.
- Use Program-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

  Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section regarding documentation for medical records.)

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by the Program, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.

- Hold confidential and use for authorized Program purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the

functioning of DMAS. DMAS shall not disclose medical information to the public.

Provider Responsibilities to Identify Excluded Individuals and Entities

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.
2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.
3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS
Attn: Program Integrity/Exclusions
600 E. Broad St, Ste 1300
Richmond, VA 23219

E-mailed to: providerexclusions@dmas.virginia.gov

Participation Conditions (Rehab)

DMAS provides coverage for physical rehabilitative services under two major programs: Outpatient Services (physical and occupational therapies and speech-language pathology services) and intensive rehabilitative services. Physical therapy and related services may be provided by acute care inpatient hospitals, rehabilitation agencies,

home health providers, outpatient units associated with hospitals, and in Comprehensive Outpatient Rehabilitation Facilities (CORFs). Intensive rehabilitation services may be provided by rehabilitation hospitals and rehabilitation units of acute care hospitals.

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. The following paragraphs outline special participation conditions for rehabilitation providers.

Rehabilitation Facilities - Inpatient

DMAS covers intensive rehabilitation services in rehabilitation hospitals and in rehabilitation units of acute care hospitals. To become a provider in this category, the facility must:

- Be certified by CMS as a rehabilitation hospital, and
- Enter into and have in effect a separate agreement as a Medicaid provider of rehabilitation services.

A copy of the agreement for rehabilitation hospitals is provided at the end of Chapter II.
Rehabilitation Facilities - Outpatient

DMAS covers intensive Comprehensive Outpatient Rehabilitation Facilities (CORFs) rehabilitation agencies, and outpatient units associated with hospitals under the conditions listed below. To become a provider in this category, the facility must:

- Submit proof of Medicare certification as a rehabilitation facility, or
- Be administered by a rehabilitation hospital, or
- Be administered by an exempted rehabilitation unit of an acute care hospital which is certified and participating in Medicaid, and
- Enter into and have in effect a separate agreement as a Medicaid provider of rehabilitation services.

A copy of the agreement for outpatient rehabilitation facilities is provided at the end of Chapter II.

Requirements of the Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in,

be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each provider enrolled in the Virginia Medical Assistance Program has the responsibility for making provisions for individuals with disabilities in the provider's programs or activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

Certification and Recertification (Rehab)

The Virginia Medicaid Program is dependent upon the participation and cooperation of physicians who provide or order many health care services. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with excellence in medical practice. For specific documentation and program requirements for rehabilitation facilities, see Chapters IV and VI of this manual.

Certifications and recertifications must be signed by the physician responsible for the case, by another physician having knowledge of the care who is authorized to sign by the responsible physician, or by the medical staff.

Documentation of Records (Rehab)

The provider agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are required documentation for medical records:

- The record must identify the patient on each page.
- The responsible licensed participating provider must sign and date the entries. The responsible licensed participating provider must countersign care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy.
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.

- The record must indicate the progress being made, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written as required for the provider type.

For other record documentation requirements, see Chapter VI.

Utilization of Insurance Benefits (Rehab)

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits is discussed below. Medicaid is the payer of last resort.

Workers' Compensation

Items and services, to the extent that payment has been made or can reasonably be expected to be made under the workers' compensation laws of Virginia, are not reimbursable by the Virginia Medicaid Program.

Other Health Insurance

When a recipient has other health insurance such as Trigon or Medicare, Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

Liability Insurance for Accidental Injuries

The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in § 8.01-66.9 of the Virginia Code. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability, or if the recipient reports a third-party responsibility (other than those cited on the Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the Home Health provider is requested to forward the DMAS-1000 to:

Third- Party Liability Unit

Department of Medical Assistance Services

600 East Broad, Suite 1300

Richmond, Virginia 23219

A copy of this form is provided in the Exhibits section following this chapter.

Assignment of Benefits (Rehab)

If a Virginia Medicaid recipient is the holder of an insurance policy that assigns benefits directly to the patient, the Home Health provider must require that benefits be assigned to the Home Health provider (or the hospital if the Home Health provider is hospital-based), or refuse the request for the itemized bill that is necessary for the collection of benefits.

Termination of Provider Participation (Rehab)

The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and Xerox-PES 30 days prior to the effective date. The addresses are:

Director

Department of Medical Assistance Services 600
East Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia Medicaid -PES PO
Box 26803

Richmond, Virginia 23261-6803

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the

termination notice.

Subsection (c) of § 32.1-325 of the Code of Virginia mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Program of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the notice of termination or denial.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or

2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing,

copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

   a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

   b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2) For services that have already been rendered, a provider appeal is:

   a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

   b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be

exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

MEMBER APPEALS

Information for providers seeking to represent a member in the member's appeal of an adverse benefit determination is located in Chapter III.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:

    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;

    - Email to appeals@dmas.virginia.gov; or

    - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-

operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Client Appeals

For client appeals information, see Chapter III of the Provider Manual.

Program Information (Rehab)

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. Currently, dissemination of this information is accomplished through the DMAS website, as well as, with regard to certain publications, by mailing such publications directly to providers, keyed to the provider number on the enrollment file. For publications that are mailed to providers, this means that each assigned provider receives program information. Since DMAS does not always know which provider groups have multiple offices or which groups use one central office, providers may receive multiple copies of such publications sent to the same location. Individual providers may request that publications not be mailed to them by completing a Mailing Suspension Request form and returning it to the Xerox-Provider Enrollment Services Unit at the address given on the form. The Mailing Suspension Request form must be completed and signed by each provider within the group who is requesting that Program information not be sent. The address is:

Virginia Medicaid - PES

PO Box 26803

Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Copies of manuals, manual updates, and certain other publications are available on the DMAS website (www.virginiamedicaid.dmas.virginia.gov). If you do not have access to the Internet, please contact DMAS' mailing contractor, Commonwealth Martin, at 804-780- 0076.

Provider Risk Category Table

Application	Rule Risk Category	App Fee Requirement Yes(Y) or No(N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y
Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N
Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate –Revalidating High – Newly enrolling	Y
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate –Revalidating High – Newly enrolling	Y
Home Health Agency - Private Owned	Moderate –Revalidating High – Newly enrolling	Y

Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate –Revalidating	Y
	High – Newly enrolling	
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N
Private Duty Nursing	Limited	N
Federally Qualified Health Center	Limited	Y
Health Department Clinic	Limited	N
Rural Health Clinic	Limited	Y
Developmental Disability Waiver	Limited	N
Alzheimer's Assisted Living Waiver	Limited	N
Treatment Foster Care Program	Limited	N
Qualified Medicare Beneficiary (QMB)	Limited	N
ICF-Mental Health	Limited	Y
ICF-MR Community Owned	Limited	Y
ICF-MR State Owned	Limited	Y
Intensive Care Facility	Limited	Y
Skilled Nursing Home	Limited	Y
SNF-Mental Health	Limited	Y
SNF-MR	Limited	Y
Psych Residential Inpatient Facility	Limited	Y
Consumer Directed Service Coordination	Limited	N
Personal Care	Limited	N
Respite Care	Limited	N
Personal Emergency Response System	Moderate –Revalidating	Y
	High – Newly enrolling	
Case Management DD Waiver	Limited	N
CMHP Transition Coordinator	Limited	N
Transition Coordinator	Limited	N
PACE	Limited	N
Family Caregiver Training	Limited	N
Mental Retardation Waiver	Limited	N
Mental Health Services	Limited - all others	Y - only for Mental Health Clinics
	Moderate -- Community Mental Health Centers	
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N

Member Eligibility

Determining Eligibility

The Department of Medical Assistance Services (DMAS) administers Virginia's medical assistance programs: Medicaid (called FAMIS Plus for children), FAMIS for children under age 19 years, and FAMIS MOMS for pregnant women. FAMIS and FAMIS MOMS offer coverage similar to Medicaid but have higher income thresholds. Per state regulations, eligibility determinations for the medical assistance programs are made by the local departments of social services (LDSS) and by the Cover Virginia Central Processing Unit (CPU).

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at www.CoverVA.org. DMAS will not pay providers for services, supplies, or equipment until the applicant's eligibility has been determined. (See "Assistance to Patients Possibly Eligible for Benefits.") Once an applicant has been found eligible, coverage for Medicaid can be retroactive for up to three months before the month in which the application was filed. A member's eligibility must be reviewed when a change in the member's circumstances occurs, and all members are subject to an annual renewal (redetermination) of eligibility.

Groups Covered by Medical Assistance

Individuals who apply for Medicaid are evaluated under the covered group or groups they meet. Each covered group has a prescribed income limit, and some covered groups also have an asset or resource limit. . Individuals may be eligible for full medical assistance coverage, including the payment of Medicare premiums for Medicaid members with Medicare, if they fall into one of the following covered groups and meet the nonfinancial and financial requirements for the group:

- Auxiliary Grants (AG) recipients
- Aged, blind or disabled (ABD) recipients of Supplemental Security Income (SSI) and certain former SSI recipients with "protected" status
- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older and/or who are eligible for or enrolled in Medicare.
- Low-Income Families with Children (parents with a dependent child under age 18 years in the home)
- Pregnant women, and postpartum women through the end of the 60-day postpartum period (Medicaid, FAMIS MOMS)
- Newborns up to age one year born to mothers who were eligible for Medicaid or covered by FAMIS or FAMIS MOMS at the time of the birth
- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.
- Children under age 19 years (FAMIS Plus, FAMIS)
- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare. These individuals are referred to as Modified Adjusted Gross Income (MAGI) Adults.
- Individuals under age 21 in institutional care
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)—women and men who were certified through the Breast and Cervical Cancer Early Detection Program.
- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care

The following individuals may be eligible for limited Medicaid coverage if they meet the nonfinancial and financial requirements for their covered group:

- Qualified Medicare Beneficiaries (QMBs) with income over 80% of the FPL but within 100% of the FPL. This group is eligible for **Medicaid coverage of Medicare premiums, deductibles, and coinsurance only**.
- Special Low-Income Medicare Beneficiaries (SLMB) with income less than 120% of the FPL. This group is eligible for Medicaid coverage of **Medicare Part B premiums only**.
- Qualified Individuals (QI) with income equal to or greater than 120% but less than 135% of the FPL. This group is eligible for Medicaid coverage of the **Medicare Part B premiums only**.
- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of **Medicare Part A premiums only**.
- Plan First – any individual with income equal to or less than 200% of FPL. This group is eligible for limited Medicaid coverage of family planning services only and not covered for full Medicaid benefits. If a member does not wish to be enrolled in Plan First, he or she should contact the local DSS to be disenrolled.

Medically Needy Covered Groups and Spenddown

Through a process known as "spenddown," Medicaid provides a limited period of full coverage for certain groups of "Medically Needy" individuals who meet all of the Medicaid eligibility requirements but have excess income for full benefit Medicaid. Individuals to which spenddown may apply include:

- ABD individuals
- Pregnant women and their newborn children
- Children under age 18
- Individuals under Age 21 in institutional care, under supervision of the Department of Juvenile Justice, foster care, or subsidized adoptions
- Individuals in long-term care institutions and those receiving services under a home and community-based care waiver or who have elected hospice care.

To be eligible for Medicaid, the individual must have incurred medical expenses that at least equal the spenddown liability. If the individual's allowable medical expenses equal the spenddown liability amount before the end of a budget period (six-month period for noninstitutionalized individuals or a one month period for institutionalized individuals), the applicant may receive a limited period of Medicaid coverage which will stop at the end of the budget period. The spenddown liability is the difference between the individual's income and the Medically Needy income limit for the individual's locality, multiplied by the number of months in the individual's spenddown period. Eligibility must be re-determined in order to establish eligibility in subsequent budget periods.

An individual placed on a spenddown does **not** have full Medicaid coverage until the spenddown is met, however they may be eligible for limited Medicaid coverage, Plan First, during the spenddown period. Medicaid cannot pay medical expenses incurred prior to the date the spenddown is met.

Emergency Medicaid Services for Aliens

To be eligible for full Medicaid benefits, FAMIS or FAMIS MOMS, an individual must be a resident of Virginia and a U.S. citizen or an alien qualified for full benefits. Individuals who do not qualify for full Medicaid benefits due to their alien status may be eligible for Medicaid coverage of emergency services if they meet all other nonfinancial and financial eligibility requirements for full Medicaid coverage.. The FAMIS and FAMIS MOMS programs do not cover emergency services for undocumented immigrants.

LDSS staff determine eligibility for receipt of emergency Medicaid coverage based on regular eligibility criteria and documentation from the provider of services that emergency services were provided. The provider may refer the individual to the LDSS or Cover Virginia (see Chapter I for information on the covered services and the coverage criteria.) For the purposes of this section, labor and delivery are considered emergency services.

Receipt of the emergency treatment will be verified by the LDSS through the member's medical record obtained from the provider. The LDSS will send a written request to the provider for the necessary documentation of the emergency service. This documentation must include all required Medicaid forms and a copy of the member's complete medical record. For inpatient hospital stays, this documentation will be the medical record for the entire hospitalization up to the 21-day limit for those over age 20.

The LDSS is authorized to approve labor and delivery services of up to three days for a vaginal delivery and five days for a cesarean section. All other services will be referred to DMAS for approval of the coverage of treatment and for establishment of the time for which this coverage will be valid.

If the member is found eligible and the emergency coverage is approved by DMAS, each provider rendering emergency care will be notified via the Emergency Medical Certification Form (#032-03-628) of the member's temporary eligibility number for coverage of the treatment of the conditions during the time stated on this form. This form will also be used to notify providers if an alien is not eligible for emergency care (See “Exhibits” at the end of this chapter for a sample of this form.).

Medicaid Eligibility for Institutionalized Individuals

An institutionalized individual is defined as one who is receiving long-term services and supports (LTSS) as an inpatient in a medical institution or nursing facility or in the home or community setting. Home and community based services (HCBS) include waiver services such as personal care, adult day health care, respite care, and the Program for All Inclusive Care for the Elderly (PACE).

To be approved for Medicaid-covered LTSS, the individual must be institutionalized in a nursing or other medical facility or have been screened and approved for HCBS. and be eligible for Medicaid in a full-benefit covered group.

If an individual is not eligible for Medicaid in any other full-benefit covered group, the individual’s eligibility in the one of the special income covered groups is determined. The policy for these groups allows a different method of determining income and resource eligibility, a higher income limit of 300% of the SSI payment for one person., An married institutionalized individual's spouse at home is

referred to as the community spouse. The community spouse is able to retain a specified amount of resources in order to continue to meet maintenance needs in the community. Some of the institutionalized spouse's monthly income may also be allocated to the community spouse if certain criteria are met. Atthe time of application for Medicaid, the LDSS completes the resource assessment document, which produces a compilation of a couple's combined countable resources at the time one spouse became institutionalized and a calculation of a spousal share (the amount of shared resources that can be allocated to the community spouse). An institutionalized spouse with a community spouse may also request a resource assessment without submitting a Medicaid application to assist with financial planning.

Most individuals receiving LTSS have an obligation toward the cost of their care, known as the patient pay. MAGI adults do not have a patent pay responsibility.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;

  Assistive technology

- Blood lead testing

- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:

  - Intensive in-home services

  - Therapeutic day treatment

- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations
- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation

- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	Co-pay Status 1	Co-pay Status 2

Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

Member Eligibility Card

A blue and white plastic eligibility card is issued to members to present to participating providers. Plan First members receive a green and white identification card. **The provider is obligated to determine that the person to whom care or service is being rendered is the same individual listed on the eligibility card.** The provider has the responsibility to request such identification as he or she deems necessary. Presentation of a plastic ID card is not proof of coverage nor guarantee of payment. A sample of an eligibility card is included under "Exhibits" at the end of this chapter.

Eligibility must be confirmed each time service is rendered. Verification can occur through a verification vendor, the voice response system or the web-based verification system. LDSS do not provide verification of eligibility to providers.

Some individuals have coverage under a Virginia Medicaid/FAMIS contracted managed care organization (MCO) and should not receive services outside their network without a referral and authorization from the MCO. These members will have an MCO card in addition to the Medicaid/FAMIS card. The verification response will advise if the member has restrictions such as a contracted MCO enrollment, or a primary payer.

The provider must determine if the service is within the dates of eligibility. These dates must be checked prior to rendering any service. Benefits are available only for services performed during the indicated period of eligibility; Medicaid/FAMIS will not pay for care or services rendered before the beginning date or after the end date of eligibility.

Bank Identifier

The top six numbers on the plastic card represent the Bank Identifier Number (BIN), which is required for pharmacy benefit cards under the National Council of Prescription Drug Programs (NCPDP).

Name of Eligible Person

An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Members enrolled in Plan First receive a green and white identification card. Check the name against another proof of identification if there is any question that the card does not belong to the member.

Member's Eligibility Number
The member's complete eligibility number is embossed on the front of the eligibility card. Eligibility numbers are distinct and permanent. When a member relocates or moves into another case, or has a break in eligibility, he keeps the same number and the same card. When members are enrolled in Plan First, they will receive a green and white identification card. This number serves as a "key" in verifying current eligibility status.

All 12 digits must be entered on Medicaid forms for billing purposes.

Date of Birth
The date of birth indicates the member's age and identifies eligibility for those services with age restrictions, such as dental care for members under age 21 and pregnant women. The date of birth should be checked prior to rendering any services. The provider should verify the age of the member. If the provider has a question as to the age of the member, means of identification other than the Medicaid/FAMIS card should be examined.

Sex
The member's gender is indicated on the card.

Card #
The sequential number of the member's card is given. If a card is lost or stolen and another Manual Title All Manuals Chapter III Page 7 Chapter Subject Member Eligibility Page Revision Date 02/22/2019 is issued, the prior card will be de-activated and will not confirm eligibility using the magnetic "swipe" mechanism.

Cardholder's Signature (signature line on back)
The signature line provides another element of verification to confirm identity

Verification of Member Eligibility

It is the obligation of the provider of care to determine the identity of the person named on the eligibility card and the current eligibility status, to include program type or MCO enrollment. It is in the best interest of the provider to review the card each time services are rendered. Possession of a card does not mean the holder is currently eligible for benefits. The member does not relinquish the card when coverage is cancelled. Replacement cards must be requested.

Program/Benefit Package Information

Members' benefits vary depending upon the program in which they are enrolled. The eligibility verification will provide information on which program the member is participating in. Examples of these programs include Medallion 3.0, Medicaid fee-forservices, FAMIS MCO, CCC Plus, FAMIS fee-for-service and Medicare premium payment.

Limited Benefit Programs for Which Members Receive Eligibility Cards

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to QMBs. There are two levels of coverage for QMBs, based on financial eligibility.

QMB Coverage Only—Members in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the member's copayment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY--QMB." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage—Members in this group are dually-eligible for full Medicaid coverage and Medicare. They are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These members are responsible for copays for pharmacy services, health department clinic visits, and vision services.

SLMBs and QIs do not receive member eligibility cards because they are not eligible for the payment of medical services rendered.

Plan First—Men and women enrolled in Plan First can receive limited Medicaid covered family planning services only, and they receive a green and white plastic Plan First identification card. This group's Medicaid verification provides the message, "PLAN FIRST - FAMILY PLANNING SERVICES ONLY." See the Plan First Manual for more information.

All Others—Members without ANY of these messages at time of verification will be eligible for those covered services listed in Chapter I of this manual.

Special Indicator Code (Copayment Code)

The Special Indicator Code indicates the status of copayments or eligibility for certain additional services. These codes are:

Code	Message
A	Under 21 - No copay exists.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care - No copay is required for any service.
C	All Other Members - Copays apply for inpatient hospital admissions, outpatient hospital clinic visits, clinic visits, physician office visits, other physician visits, eye examinations, prescriptions, home health visits, and rehabilitation service visits. (Some verification methods may return a yes/no response. Yes = copays apply. No = copays do not apply)

The following copay exemptions apply:

- Members in managed care organizations may not have to pay copays.
- Pregnancy-related services or family planning clinic visits, drugs, and supplies are exempt from copays for all members.

- No copayments apply for any emergency services for any member, with one exception for members in Client Medical Management with a pharmacy restriction. Please refer to the Client Medical Management exhibit in Chapter I for more information on this exception.

The Medicaid member co-pays are located in Chapter IV.

The FAMIS member co-pays are:

Service*	Co-pay Status 1	Co-pay Status 2
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

Insurance Information The “Insurance Information” in the verification response indicates any type of insurance coverage the member has in addition to Medicaid. This information includes specific insurance companies, dates of coverage, policy numbers, and a code that specifies the particular type of coverage of the policy. These items are:

Carrier Code	A three-digit code indicating the name of the insurance carrier, e.g. 001 for Medicare (See Insurance Company Code List for these code numbers in “EXHIBITS” at the end of this chapter.) If the carrier code is 003 (not listed), call the member’s local eligibility worker for assistance in obtaining the name of the insurance carrier.
Begin Date	The first date on which this insurance policy was effective
Type Code	An alpha character describing the type of coverage provided by the policy, such as a "D" for dental coverage. (See the Type of Coverage Code List under “EXHIBITS” at the end of this chapter for a list of these codes.)
Policy Number/ Medicare Code	The specific policy or Medicare number for the insurance identified by the Carrier Code

Only insurance information for active policies during the period for which eligibility is requested is provided at verification. If the member reports insurance information different from what is on the card, refer the member to his or her LDSS eligibility worker to correct the data so bills will be processed correctly.

Under the assignment of benefits regulations, DMAS can act on behalf of the member (subscriber) and recover third-party payment from the primary carrier. Workers' Compensation and other liability insurances (e.g., automobile liability insurance or home accident insurance) are always considered as primary carriers for cases where coverage is applicable to the injury being treated. Because the member's eligibility card cannot indicate this coverage, it is necessary that cause-of-

injury information be obtained from the member.

Primary Care Providers (PCPs) for the Client Medical Management Program

A primary care designation or restriction is imposed by the Member Monitoring Unit of DMAS as a result of high utilization of services by the member causing unnecessary or duplicate services. Eligibility verification will list the names of designated primary care providers (physician and/or pharmacy). The designated providers must agree to the relationship prior to the designation appearing on the member's card. Unless it is an emergency, do not provide services without contacting the primary care provider first for authorization.

Managed Care Programs

Most Medicaid members are enrolled in one of the Department’s managed care programs (Medallion 3.0, Medallion 4.0, CCC Plus, PACE). Each program has specific eligibility requirements and health plan assignment criteria for its members. For more information, please contact the individual’s managed care plan/PACE provider directly.

Contact and/or eligibility and assignment information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 3.0:
  http://www.dmas.virginia.gov/#/med3
- Medallion 4.0:
  http://www.dmas.virginia.gov/#/med4
- Commonwealth Coordinated Care Plus (CCC Plus):
  ttp://www.dmas.virginia.gov/#/cccplus
- Program of All-Inclusive Care for the Elderly (PACE):
  http://www.dmas.virginia.gov/#/longtermprograms

Member Without an Eligibility Card

A member who seeks services without a current eligibility card should be considered responsible for all charges incurred unless eligibility is verified. The provider can verify eligibility without the card using two other identification keys, including name, Social Security Number, and date of birth. These can be used to access the MediCall automated System, the verification vendors, and the web verification system (ARS). See Chapter I for further information about verification methods. LDSS do not provide verification of eligibility to providers.

Assistance to Patients Possibly Eligible for Benefits

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover Virginia Call Center at 1-855-242-8282 for an application for health care coverage. The LDSS or Cover Virginia will notify the patient of eligibility or ineligibility. Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility. The effective

date of Medicaid eligibility may be retroactive up to three months prior to the month in which the application was filed, if the patient was eligible during the retroactive period. Once a patient is found eligible, providers may bill Medicaid for covered services, and upon receipt of payment from Medicaid, must reimburse the patient for the out-of-pocket expenses; Medicaid does not reimburse members for out-of-pocket expenses.

Medicaid Applications -- Authorized Representative Policy

Medicaid eligibility requirements are strict and require an applicant or someone conducting business on his or her behalf to attest to citizenship or alien status, declare all income and assets, and make assignment of insurance and medical support benefits. In order to accurately determine eligibility, LDSS must ensure that an individual who files an application or someone conducting business on behalf of the applicant has full knowledge of the applicant's situation and can provide correct information.

A Medicaid applicant must sign the application form unless the application is filed and signed by the applicant's legal guardian or conservator, attorney-in-fact, or other person who is authorized to apply on the applicant's behalf. If the applicant is unable to sign his or her name but can make a mark, the mark must be designated "his/her mark" and witnessed by one person.

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless he or she is legally emancipated from his or her parents. If a child is not legally emancipated, his or her parent or legal guardian, an authorized representative designated by the parent or legal guardian, or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age may apply for Medicaid on behalf of his or her own child.

A legally competent individual age 18 or older may authorize anyone age 18 or older to file a Medicaid application on his or her behalf provided that the authorization is in writing, identifies the individual or organization authorized to conduct business on his or her behalf, and is signed by the individual giving the authorization.

When an individual has been determined by a court to be legally incompetent or legally incapacitated, the individual's legally appointed guardian or conservator is the individual's authorized representative and can apply for Medicaid on the individual's behalf. If an individual does not have a legal guardian or authorized representative and is mentally unable to sign an application or designate a representative, the individual's spouse will be considered the authorized representative for Medicaid purposes. In situations where the individual is not married, is estranged from his or her spouse, or the spouse is unable to represent him or her, a relative of the individual who is willing to take responsibility for the individual's Medicaid business may be considered his or her authorized representative. Relatives who may be considered authorized representatives in this situation are, in the following order of preference: the individual's adult child; parent; adult sibling; adult niece or nephew; or adult aunt or uncle.

If it is determined that an individual cannot sign an application and does not have an attorney in-fact or authorized representative, a Medicaid application may be filed by someone other than an authorized person provided the individual's inability to sign the Medicaid application is verified by a written statement from the individual's doctor. The statement must indicate that the individual is

unable to sign and file a Medicaid application because of his or her diagnosis or condition. The LDSS will pend the application until it can be appropriately signed if it is determined that court action has been initiated to have a guardian or committee appointed for the individual or until an Adult Protective Services investigation concludes that guardianship proceedings will not be initiated. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.

An application may be filed on behalf of a deceased person by his or her guardian or conservator, attorney-in-fact, executor or administrator of his or her estate, surviving spouse, or a surviving family member, in the following order of preference: adult child, parent, adult sibling, adult niece or nephew, or adult aunt or uncle. The application must be filed within a three-month period subsequent to the month of the individual's death. Medicaid coverage can be effective no earlier than three months prior to the application month. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

Non-Medicaid Patient Relationship

Medicaid-eligible members who elect to be treated as private patients or who decline to verify their Medicaid eligibility with providers will be treated as private pay patients by the provider and by DMAS. Providers are required to furnish supporting documentation whenever patients fall into either of these categories.

Newborn Infant Eligibility

All newborn days, including claims for "well babies," must be submitted separately. "Well baby" days cannot be processed as part of the mother's per diem, and no information related to the newborn must appear on the mother's claim.

A newborn is automatically considered eligible for Medicaid or FAMIS through age 1 year if the newborn's mother was eligible for full coverage Medicaid or enrolled in FAMIS or FAMIS MOMS at the time she gave birth. A medical assistance application must be filed for any child whose mother was not eligible for Medicaid or enrolled in FAMIS/FAMIS MOMS at the time of the child's birth.

An easy, streamlined way for hospitals to report the birth of the newborn is through the Medicaid Web Provider Portal www.virginiamedicaid.dmas.virginia.gov under the link "E213". Any hospital staff that have approval from their hospital and have access to the portal may report the newborn's birth and receive the newborn's Member ID within 2 business days via email. The provider can verify newborn eligibility from the card using two other identification keys, including name, social security number, and the date of birth. These can be used to access MediCall, the verification vendors, and the web-based system, ARS.

See Chapter I: General Information for more information on eligibility verification.

Medicaid Eligibility for Hospice Services

To be eligible to elect hospice as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked concurrently under both programs.

Guidelines on Institutional Status

Federal regulations in 42 CFR 435.1009 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution, and
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An Intermediate Care Facility for the Intellectually Disabled (ICF-ID) is not an IMD.

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

An individual is considered incarcerated until permanent release, bail, probation or parole. An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid. The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds.

Incarcerated Individuals

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer, provided they meet all other Medicaid eligibility requirements.

Incarcerated individuals include:

- individuals under the authority of the Virginia Department of Corrections (DOC) or Virginia Department of Juvenile Justice (DJJ), and
- individuals held in regional and local jails, including those on work release.

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail or juvenile facility.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

Once an individual is released from the correctional facility, he can be enrolled in full benefit Medicaid, provided he meets all Medicaid eligibility requirements.

Juveniles

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and postdisposition situations, and types of facilities.

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- Juvenile who is in a detention center due to criminal activity
- Juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site: http://www.djj.virginia.gov/Residential_Programs/Secure_Detention/pdf/Detention_Home_Contacts_02242011rev.pdf.

If they go to a non-secure group home, they can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center. A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible for full-benefit Medicaid if he/she is a resident of an ineligible public residential facility. He can be eligible for Medicaid coverage limited to inpatient hospitalization if he is admitted to a medical facility for inpatient services.

Who is Not an Inmate of a Public Institution

An individual is NOT an inmate of a public institution if:

- The individual is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- The individual is in a public institution for a temporary period pending other arrangements appropriate to his needs. Individuals in public institutions for a temporary period include:
  - individuals admitted under a TDO
  - individuals arrested then admitted to a medical facility
  - inmates out on bail
  - individuals on probation (including a juvenile on conditional probation or probation in a secure treatment center), parole, or conditional release
  - juveniles in a detention center due to care, protection or in their best interest.

Member Appeals

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an authorized representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. Members who are enrolled in an MCO may appeal to the MCO or directly to DMAS. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was sent, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the member may be expected to repay DMAS for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If services are continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Member appeals must be requested in writing and postmarked or submitted within 30 days of receipt of the notice of adverse action. The member or his authorized representative may complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

If the member is not able to get the form, he may write a letter. The letter must include the name of

the person whose request for benefits was denied, reduced, or cancelled. Also, the letter must include the person's date of birth, social security number, case number, the agency that took the action, and the date of the action.

A copy of the notice or letter about the adverse action should be included with the appeal request. The appeal request must be sent to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street, 6th Floor
Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 452-5454

The Appeals Division will notify members of the date, time and location of the hearing if the appeal is valid and a hearing is granted. The hearing will be conducted by a DMAS Hearing Officer. Most hearings will be done by telephone.

The Hearing Officer's decision is the final administrative decision by DMAS. If the member does not agree with the Hearing Officer's decision, he/she may appeal it directly to the circuit court in the city or county of residence.

Covered Services and Limitations (Rehab)

Freedom of Choice (Rehab)

According to federal requirements 42 Code of Federal Regulations (CFR) 431.51, Medicaid eligible individuals must be offered a choice of service provider(s) and this must be documented in the individual's medical record.

Medallion 3.0 (Rehab)

In areas where the Medallion 3.0 program is available, many Medicaid individuals receive primary and acute care through mandatory enrollment in managed care organizations (MCOs). Medallion 3.0 MCO individuals may be identified by their MCO Individual Identification Card or by other Medicaid eligibility verification systems. Medicaid individuals enrolled in the traditional Medicaid program will have a regular Medicaid card. MEDALLION 3.0 individuals have a regular Medicaid card and a MCO Individual Identification Card. Except for family planning and emergency services, Medallion 3.0 individuals must utilize providers that participate within the MCO's provider network. Providers must adhere to the MCO's requirements regarding referrals and Service Authorization requirements, otherwise, payment for services may be denied. Providers may not bill the individual for Medicaid covered services, including in those instances where a provider fails to follow the MCO's established guidelines.

Refer to the section entitled “MEDALLION 3.0” in Chapter I of this manual for further details regarding individuals who are enrolled in MEDALLION 3.0.

Commonwealth Coordinated Care (CCC) Program (Rehab)

The Commonwealth Coordinated Care (CCC) program is a new initiative, as of April 2014, to coordinate care for individuals who are currently served by both Medicare and Medicaid and meet certain eligibility requirements. The program is designed to be Virginia’s single program to coordinate delivery of primary, preventive, acute, behavioral, and long-term services and supports focused on the individual’s needs and preferences. Additional information on the CCC program can be accessed at: http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx.

Virginia Medicaid Web Portal

The Virginia Medicaid Web Portal is the gateway for providers to transact all Medicaid and FAMIS (Family Access to Medical Insurance Security Plan) business via one central location on the Internet. The web portal provides access to Medicaid Memos, Provider Manuals, providers search capabilities, provider enrollment applications, training and education. Providers must register through the Virginia Medicaid Web Portal in order to access and complete secured transactions such as verifying Medicaid eligibility, service limits and service authorization or by submitting a claim. The Virginia Medicaid Web Portal can be accessed at: www.virginiamedicaid.dmas.virginia.gov.

Rehabilitation Definition

Rehabilitation services is medically prescribed treatment designed to improve or restore functions which have been impaired by illness, disability, injury or, where function has been permanently lost or reduced by illness or injury, to improve or restore the individual’s ability to perform those tasks required for independent functioning.

Covered Services (Rehab)

Inpatient and outpatient rehabilitation services are covered services available to the entire Medicaid population. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by a physician; a reasonable and medically necessary part of the individual’s treatment plan; consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and is furnished at a safe, effective, and cost-effective level.

Providers of Service (Rehab)

The Department of Medical Assistance Services (DMAS) provides coverage for physical rehabilitative services under two programs: outpatient rehabilitation (physical and occupational therapies and speech-language pathology services) and intensive rehabilitation services.

Implemented in 1978, the outpatient rehabilitation services may be provided in hospital outpatient settings of acute care and rehabilitation hospitals, rehabilitation agencies, home health agencies, and nursing facilities.

Implemented in February 1986, the intensive inpatient rehabilitation program provides comprehensive rehabilitation services that include the following: rehabilitation nursing, physical therapy, occupational therapy, cognitive rehabilitation therapy, speech-language pathology services, and, if needed, social work services, psychology, therapeutic recreation, and durable medical equipment. These services may be provided by a freestanding rehabilitation hospital, a Comprehensive Outpatient Rehabilitation Facility (CORF), or by an acute care hospital that has a Medicare-exempt physical rehabilitation unit.

All rehabilitative services must be prescribed by a physician and be a part of a written plan of care/treatment plan that the physician reviews periodically (described later in this chapter).

There are various requirements for physician documentation for intensive rehabilitation, CORF, and outpatient rehabilitation services. Refer to this Chapter and Chapter VI for intensive/CORF and outpatient rehabilitation specific documentation requirements related to the physician, physician assistant, and the nurse practitioner. If therapy services are ordered by a practitioner of the healing arts other than a physician, supervision must be performed by a physician as required by the Virginia Department of Health Professions regulations. (Virginia State Code § 54.1-2400; 42 Code of Federal Regulations (CFR), 440.130, and 485.711).

To be reimbursed for services rendered, each provider must have a valid signed provider agreement and a valid NPI number with the DMAS for the type of services that are being provided. For additional provider information, refer to Chapter II of this manual.

NOTE: For additional services related to children under the age of 21, including but not limited to, EPSDT, Early Intervention Services (EIS), FAMIS and School Services, refer to the Maternal and Child Health Programs section of the DMAS web site at:

http://www.dmas.virginia.gov/Content_pgs/mch- home.aspx. The DMAS Medicaid web portal contains the program manuals located at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Out of State Rehabilitation Services

[Applicable for both Inpatient & Outpatient Rehabilitation]

DMAS may negotiate individual arrangements with in-state or out-of-state rehabilitation facilities for Virginia Medicaid individuals with special intensive inpatient rehabilitation needs.

Out of state rehabilitation providers are defined as those providers that are either physically outside the borders of the Commonwealth of Virginia or do not provide year end cost settlement reports to DMAS. These providers must be enrolled with Virginia Medicaid (provider class type 091 – Out of State Hospital) in order to submit claims for reimbursement. Service authorization is required.

Out of state or border rehabilitation providers, located close to the proximity of the Virginia state borders (MD, WVA, KY, TN, and NC) and who are enrolled with Virginia Medicaid as a provider class type 085 (Out of State Rehab Hospital) must submit service authorization requests to DMAS or its Service Authorization Contractor as described in Appendix D of this manual.

NOTE: Out of State Providers must refer to the DMAS Medicaid Memo dated February 6, 2013 and also refer to Appendix D titled "Service Authorization Information" of this manual, for more specific information and guidelines.

For those out of state rehabilitation hospital providers who do not meet the above described requirements, a written inquiry may be submitted to DMAS – Division of Long Term Care for additional consideration at: dmas-info@dmas.virginia.gov. Providers must be specific about the services they are requesting and the justification for out of state services. Providers must be enrolled prior to providing services.

NOTE: If Virginia does not offer an inpatient rehabilitation program that provides ventilator weaning, then out of state options may be considered. If a newly acquired ventilator dependent individual within an acute care hospital would benefit from an inpatient rehabilitation program and possible ventilator weaning, the acute care hospital may submit a written inquiry to DMAS - Division of Long Term Care for additional consideration at: dmas-info@dmas.virginia.gov.

Applicable regulations for out-of-state services: 42 CFR §431.52, 12 VAC 30-90-10, 12

VAC 30-10-120, 12 VAC 30-50-225, 12 VAC 30-50-140, 12 VAC 30-60-21, 12 VAC 30-70-420, 12 VAC 30-80-120

Intensive Rehabilitation Services

Intensive rehabilitation program criteria and policy guidelines can be found in the

Virginia Administrative Code, 12VAC 30-50-225, 12 VAC 30-60-20, and 12 VAC 30-

60-120. Effective January 1, 2016, the 12 VAC 30-50-225 and 30-60-120 were revised. Rehabilitation providers have a responsibility to know the regulatory requirements for rehabilitation.

Admission Criteria (Including CORF)

An individual is deemed to require either intensive inpatient rehabilitation services or comprehensive outpatient rehabilitation facility (CORF) services if both of the following criteria are met:

- An intensive rehabilitation program consisting of an interdisciplinary coordinated team approach is required to improve the individual's ability to function as independently as possible; and

- Documentation exists that the rehabilitation program cannot be safely and adequately carried out in a less intensive setting (such as outpatient rehabilitation or home health services).

In addition to the above requirements, individuals must also meet all of the following criteria:

- The individual requires rehabilitative nursing (for patient/family education and teaching in addition to skilled nursing care);
- The individual requires at least two of the four listed therapies:
  - Physical Therapy
  - Occupational Therapy
  - Cognitive Rehabilitation Therapy
  - Speech-Language Pathology Services;

- The individual is able to actively participate in therapy on a daily basis;
- The medical condition is stable and compatible with an active rehabilitation program; and
- The individual meets InterQualÒ criteria upon admission and for continued stay. The InterQualÒ criteria may be obtained through McKesson Health Solutions LLC. For the McKesson mailing address, phone and fax numbers and the InterQualÒ web site address, refer to Appendix D. of this manual, which contains service authorization information.

NOTE: Admissions for evaluation and/or training solely for vocational or educational purposes or for developmental or behavioral assessments are not covered services.

If the individual had a previous hospital stay and completed a rehabilitation program for essentially the same condition for which this admission is now being considered, reimbursement for the evaluation will not be covered unless a justifiable and documented intervening circumstance necessitates a re-evaluation.

Guidelines for Initiating and Continuing Therapy [Applicable for both Inpatient & Outpatient Rehabilitation]

- *Maintenance Therapy* - Interpreted as: 1) the point in therapy where the individual demonstrates no further significant improvement, *or* 2) the skills of a qualified rehabilitative therapist are not required to carry out an activity or a home program to maintain functioning at the level to which it has been restored. These services are not covered by Medicaid.
- *Improvement of Function* – Interpreted as rehabilitative therapy designed to improve function and based on an expectation that: 1) the therapy will result in a significant improvement in an individual's level of functioning within a reasonable period of time;

  2) there is a valid expectation of improvement at the time the rehabilitative therapy program is implemented; and 3) the services would be recognized even though the expectation may not be realized.

For continued intensive rehabilitation services, the individual must demonstrate an

ability to actively participate in goal-related therapeutic interventions developed by the interdisciplinary team and demonstrate progression toward the established goals.

Therapeutic Furlough Days

DMAS will not reimburse an inpatient rehabilitation provider for days when an individual is on an overnight therapeutic furlough. Properly documented rehabilitative reasons for the furlough days should occur as a part of the inpatient rehabilitation program. Such days must not be billed.

Transfer to Acute Care/Readmit to Rehabilitation

When an individual requires transfer to an acute care setting for more than 24 hours, the individual must be discharged from the intensive rehabilitation program. When the individual is medically stable and continued intensive rehabilitation services are appropriate, the individual should be readmitted to the intensive rehabilitation program.

For re-admissions after hospitalizations of more than 24 hours, the rehabilitation treatment team disciplines must re-evaluate the individual's functional status and document the findings in the individual's medical record. Service authorization through the DMAS contractor is required. Each team discipline must review and sign/date the current plan of care/treatment and document whether changes to the current plan are necessary. The physician must document a re-admission note to review the medical necessity for the transfer and the appropriateness for the individual to continue with the intensive rehabilitation program. Physician admission certification is required to be documented.

Discharge/Termination from Services

[Applicable for <u>both</u> Inpatient & Outpatient Rehabilitation]

Rehabilitation services must be considered for termination, regardless of the service authorized or approved length of stay, when further progress toward the established rehabilitation goal is unlikely or further rehabilitation treatment can be achieved in a less intensive setting, such as in nursing facilities, home and community based settings, home health agencies, and/or outpatient rehabilitation agencies.

Intensive rehabilitation services must be considered for termination when any <u>one</u> of the following conditions is met:

- No further potential for improvement is demonstrated. The specialized knowledge and skills of a licensed/registered rehabilitative therapist are no longer required for safe and effective provision of such rehabilitation services. The individual has reached his/her maximum progress and a safe and effective maintenance program has been developed;
- There is limited motivation on the part of the individual or caregiver;
- The individual has an unstable condition that affects his/her ability to participate in an intensive inpatient/comprehensive rehabilitative plan;
- Progress toward an established goal or goals cannot be achieved within a reasonable period of time;
- The established goals serve no purpose to increase functional or cognitive capabilities; or
- The service can be provided by someone other than a licensed or registered/certified rehabilitation professional.

Provider and Service Requirements for Intensive Rehabilitation Services

All practitioners and providers of services shall be required to meet current state and federal licensing and/or certification requirements as follows:

A physician must: 1) complete the admission certification of intensive rehabilitation services; 2) complete initial plan of care orders; 3) complete a 60-day recertification, if applicable (or a licensed practitioner of the healing arts, such as a nurse practitioner or a physician assistant, within the scope of his/her practice under State law). If therapy services are recertified by a practitioner of the healing arts other than a physician, supervisory requirements must be performed by a physician as required by the Virginia Department of Health Professions regulations. [Virginia State Code § 54.1-2857.02; 42 Code of Federal Regulations, 456.60 (a)(1)(b)(1), 456.80 (a)].

A physician is responsible for all documentation requirements, including but not limited to, admission certifications, recertifications, plan of care orders, progress notes, etc., as defined in this Chapter and in Chapter VI of this manual. [42 Code of Federal Regulations, 485.58 (a)(1)]. NOTE: CORF provider requirements do not permit a nurse practitioner or a physician assistant to order intensive rehabilitation services.

Physician

Physician services require that the physician have special knowledge and clinical skills and experience in the field of rehabilitation or another related field, be licensed by the Virginia Board of Medicine, be legally authorized to practice, and act within the scope of his or her license.

The physician must meet all of the following requirements:

- Provide evidence of a written physician admission certification statement (DMAS-127) and, if applicable, a physician recertification statement (DMAS-128) every 60 days;
- Develop the initial plan of care orders/treatment plans for rehabilitative therapy services to include specific procedures and modalities;
- Identify the specific discipline(s) to carry out the plan of care/treatment plan;
- Indicate the frequency and duration of services (i.e.: 1 hour daily for 5 days per week for a 4 week estimated length of stay);
- Participate at least biweekly in treatment plan reviews and interdisciplinary team conferences;
- Consult with team disciplines, as needed, in providing a comprehensive approach to the treatment plan;
- Provide evidence of a written review (DMAS-126) of the physician plan of care orders/treatment plan every 60 days;
- Complete a discharge order upon the individual's discharge from rehabilitation services.

NOTE: Refer to Chapter Six of this manual for more information on the DMAS-126, 127 and 128 physician forms.

Rehabilitative Nursing

Rehabilitative nursing services require that nurses have education, training, and/or experience which provide special knowledge and clinical skills to diagnose nursing needs and treat individuals who have health problems characterized by alterations in

cognitive and functional ability. Rehabilitative nursing services are those services provided to an individual which meet all of the following conditions:

- The services shall be directly and specifically related to an active written plan of care/treatment plan approved by a physician;

- The services shall be of a level of complexity and sophistication, or the condition of the individual shall be of a nature that the services can only be performed by a registered nurse, licensed professional nurse, nursing assistant, or rehabilitation technician under the direct supervision of a registered nurse who is experienced in rehabilitation;
- The services shall be provided with the expectation, based on the assessment made by the physician that the condition of the individual will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis;
- The services shall be specific and provide effective treatment for the individual's condition in accordance with accepted standards of medical practice and include the intensity of rehabilitative nursing services, which can only be provided in an intensive rehabilitative setting; and
- Once the individual no longer requires rehabilitative nursing services, the registered nurse (RN) or the licensed practical nurse (LPN) under the supervision of an RN, must complete a discharge summary.

Physical Therapy

Physical Therapy services are those services provided to an individual that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by a physician after any needed consultation with a physical therapist (LPT) licensed by the Virginia Board of Physical Therapy. (12 VAC 30-60-120 and 18 VAC 112-20-30). The *Code of Federal Regulations* (42 CFR 440.110) require that the therapist meet licensure requirements within the scope of the practice under State law;
- The services must be of a level of complexity and sophistication or the condition of

the individual shall be of a nature that the services can only be performed by a licensed physical therapist or a physical therapy assistant, (LPTA) who is licensed by the Virginia Board of Physical Therapy, under the direct supervision of a qualified physical therapist (18 VAC 112-20-100);

- The services shall be provided with the expectation, based on the assessment made by the physician, that the condition of the individual will improve significantly in a reasonable and generally predictable period of time, or the services shall be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and
- The services must be specific and provide effective treatment for the individual's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

NOTE: Physical therapy that can be performed by supportive personnel (such as physical therapy aides, nursing staff, volunteers, etc.) does not meet DMAS criteria for reimbursement as physical therapy services. There is no provision for Medicaid reimbursement for students rendering physical therapy services.

Only a licensed physical therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate an individual's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a licensed physical therapist (LPT) are required to evaluate the individual's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a licensed physical therapy assistant (LPTA) functioning under the direct supervision of a licensed physical therapist.

NOTE: For more information on 30-day supervision documentation requirements, refer to the section after speech-language therapy in this chapter and Chapter VI of this manual.

If an adequate number of qualified personnel are not available to carry out the

physician order, particularly related to the frequency of service, the therapist will inform the physician of this fact and document the response of the physician in the medical record. The plan of care will be revised accordingly with physician written approval.

Physical therapy is not required to improve or restore function where an individual suffers a temporary loss or reduction of function (e.g., temporary weakness which may follow prolonged bed rest following major abdominal surgery) that could reasonably be expected to spontaneously improve as the individual gradually resumes normal activities. Physical therapy for temporary loss of function will not be covered.

Once the individual no longer requires therapy services, the LPT must complete a discharge summary documenting the individual's goal achievements and outcomes and any recommendations.

Physical Therapy includes, but is not limited to, the following modalities and procedures:

These modalities are appropriate for both intensive rehabilitation services and for outpatient rehabilitation services. This list is not all inclusive.

- Gait Training; Ambulation activities
- Range of Motion Activities
- Ultrasound, Shortwave, and Microwave Diathermy Treatments
- Therapeutic Exercises (e.g., strengthening, stretching, tilt table activities, etc.)
- Hot Pack, Hydrocollator, Infrared Treatments, and Whirlpool Baths

Maintenance Activities – Not Reimbursed

Exercises or maintenance activities (e.g.: active or passive range of motion, that are not related to the restoration of a specific loss of function) can ordinarily be provided safely by supportive personnel (such as physical therapy aides, nursing staff, volunteers, etc.), and do not require the skills of a licensed physical therapist or licensed physical therapy assistant. These activities will not be reimbursed. For example, passive exercises to maintain range of motion in paralyzed extremities, can be carried out by physical therapy aides or nursing staff, and will not be considered rehabilitation therapy requiring the skills of licensed therapy staff and, therefore, will not be reimbursed.

Occupational Therapy

Occupational therapy services are those services provided to an individual that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by the physician after any needed consultation with an occupational therapist registered and licensed (OTR) by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine (12 VAC 30-60-120 and 18 VAC 85-80-10 et seq.). The *Code of Federal Regulations* (42 CFR 440.110) requires that the therapist meet licensure requirements within the scope of the practice under state law;

- The services shall be of a level of complexity and sophistication or the condition of the individual must be of a nature that the services can only be performed by a licensed occupational therapist *or* an occupational therapy assistant (COTA) certified by the National Board for Certification in Occupational Therapy under the direct supervision of a qualified occupational therapist;

- The services shall be provided with the expectation, based on the assessment made by the physician, that the condition of the individual will improve significantly in a reasonably and generally predictable period of time, or the services shall be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the individual's condition in accordance with accepted standards of medical practices; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

NOTE: Occupational therapy that can be performed by supportive personnel (such as occupational therapy aides, nursing staff, volunteers, etc.) does not meet DMAS criteria for reimbursement as occupational therapy services. There is no provision for Medicaid reimbursement for students rendering therapy services.

Only a registered and licensed occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate an individual's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a registered and licensed occupational therapist are required to evaluate the individual's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a certified

occupational therapy assistant (COTA) functioning under the direct supervision of a registered and licensed occupational therapist.

NOTE: For more information on 30-day supervision documentation requirements, refer to the section after speech-language therapy in this chapter and Chapter VI of this manual.

If an adequate number of qualified personnel are not available to carry out the physician order, particularly related to the frequency of service, the therapist will inform the physician of this fact and document the response of the physician in the medical record. The plan of care will be revised accordingly with physician written approval.

Once the individual no longer requires therapy services, the OTR must complete a discharge summary documenting the individual's goal achievements and outcomes and any recommendations.

Occupational therapy includes, but is not limited to, the following modalities and procedures:

These modalities are appropriate for both intensive rehabilitation services and for outpatient rehabilitation services. This list is not all inclusive.

- The evaluation and re-evaluation, as required, to assess an individual's level of function by administering diagnostic and prognostic tests;
- The selection and teaching of task-oriented therapeutic activities designed to restore physical function;
- The planning, implementing, and supervising of an individualized therapeutic activity program as part of an overall active treatment program (e.g., the use of computer activities that require following multi-level directions, and assist with memory loss);

- The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function (e.g., providing motor and tactile activities to increase sensory input and improve response); and
- The teaching of compensatory techniques to improve the level of independence in the activities of daily living.

Speech-Language Pathology

Speech-language pathology services are those services provided to an individual that meet all of the following conditions:

- Services are directly and specifically related to an active written plan of care/treatment plan designed by a physician after any needed consultation with a speech-language pathologist with a Master's degree, licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology (12 VAC 30-60-120 and 18 VAC 30-20-170). The *Code of Federal Regulations* (42 CFR § 440.110) require that the therapist meet licensure requirements within the scope of the practice under state law;
- Services are of a level of complexity and sophistication or the condition of the individual must be of a nature that the services can only be performed by any **one** of the following:
- A speech-language pathologist (SLP) with a Master's Degree who is licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech- Language Pathology; **or**
- An individual licensed by the Virginia Board of Audiology and Speech-Language Pathology who meets **one** of the following:

a. Has a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA); **or**

b. Has completed the Masters level academic program and is acquiring supervised work experience to qualify for the ASHA certification.

   This individual is in the Clinical Fellowship Year (CFY), and is under the direct supervision of a licensed CCC/SLP or SLP, which includes initial direction and periodic observation of the actual performance of the therapeutic activity.

When services are provided by a CFY/SLP, a licensed CCC/SLP or SLP must make a supervisory visit at least every 30 days while therapy is being conducted and document accordingly;

c. DMAS will reimburse for the provision of speech-language services when provided by a speech-language assistant who has either a Bachelors level or a Masters level without licensure by the Board of Audiology and Speech Language Pathology. The unlicensed assistant (and the fact that they do not meet qualification requirements to bill Medicaid) shall be disclosed to the individual, their family, caregiver, or legally authorized representative prior to treatment, and documented and made a part of the individual's record. In order to bill Medicaid, these speech-language assistants must be under the direct supervision of a licensed CCC/SLP or SLP that meets DMAS' licensure requirements.

The services must be provided with the expectation, based on the assessment made by the physician of the individual's rehabilitation potential, that the individual's condition will improve significantly in a reasonable and generally predictable period of time, or the services are to establish a safe and effective maintenance program in connection with a specific diagnosis; and

The services must be specific and provide effective treatment for the individual's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

NOTE: Speech-language pathology services that can be performed by supportive personnel (such as speech aides, nursing staff, volunteers, etc.) does not meet the DMAS criteria for reimbursement as speech-language pathology services. There is no provision for Medicaid reimbursement for students rendering therapy services.

Only a licensed speech-language pathologist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate an individual's level of

function; determine whether a speech-language therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a qualified speech-language therapist are required to evaluate the individual's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a speech-language assistant functioning under the direct supervision of a qualified speech-language therapist.

NOTE: For more information on 30-day supervision documentation requirements, Refer to the section after speech-language therapy in this chapter and Chapter Six of this manual.

A licensed speech-language pathologist is required to evaluate an individual's level of function and develop and sign/date a plan of care/treatment plan. The implementation of the plan may be carried out by one of the following: SLP, CCC/SLP, and CFY/SLP, or speech-language assistants as identified above.

If an adequate number of qualified personnel are not available to carry out the physician order, particularly related to the frequency of service, the therapist will inform the physician and document the response of the physician in the medical record. The plan of care will be revised accordingly with physician written approval.

Once the individual no longer requires therapy services, the SLP must complete a discharge summary documenting the individual's goal achievements and outcomes and any recommendations.

Speech-language pathology services include, but are not limited to, the following modalities and procedures:

These modalities are appropriate for both intensive rehabilitation services and for outpatient rehabilitation services. This list is not all inclusive.

- Assistance to the physician in evaluating individuals to determine the type of speech or language disorder and the appropriate corrective therapy.

- Rehabilitative services for speech, language, voice, or communication disorders, language comprehension and expression (i.e.: receptive and expressive language).
- Rehabilitative services for swallowing disorders, cognitive problems, speech fluency and sound production (i.e.: articulation, phonological process, apraxia, dysarthria), etc.

Reimbursement for speech-language pathology services is limited to those services related to a medical diagnosis. *Long-term* speech-language pathology services are not covered under intensive inpatient rehabilitation but may be covered under outpatient rehabilitation services based on the individual's diagnosis, progress and treatment plan.

Therapist Supervision of a Therapy Assistant (Applicable to PT, OT, and SLP)

[Applicable for Intensive, CORF, and Outpatient Rehabilitation]

Direct on-site supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the licensed therapist (not the therapy assistant). When services are provided by a licensed or certified therapy assistant (i.e.: PTA, COTA, CFY/SLP or Speech-Language Assistant), the licensed therapist (i.e.: PT, OT, or SLP) must conduct an on-site supervisory visit at least every 30 days while therapy is being conducted, observe, and document accordingly.

If the supervisory therapist co-signs the assistant's progress visit notes, this action alone does not constitute a 30-day supervisory visit note. The supervisory therapist shall review the progress notes of the therapy assistant. The supervisory therapist documentation of the 30-day note shall include a review of the plan of care with the assistant and comments on any adjustments or revisions to the individual's therapy goals, as needed. If no adjustments or revisions are needed, the therapist should document accordingly. The supervisory 30-day review note must be signed, titled and fully dated by the therapist. Lack of documentation of the 30-day supervisory visit

notes will result in a DMAS audit retraction of provider reimbursement.

Cognitive Rehabilitation Therapy

The provision of cognitive rehabilitation is included in *the State Plan for Medical Assistance* as a component of rehabilitation for severely neurologically impaired individuals, such as, for example, those with traumatic brain injury (TBI), severe cerebral vascular accident (CVA; stroke), anoxic injuries, and intracranial hemorrhage.

Cognitive rehabilitation services are those services furnished to an individual that meet all of the following conditions:

- The services are directly and specifically related to an active written plan of care/treatment plan designed by the physician after any needed consultation with a Virginia licensed clinical psychologist or physician experienced in working with the neurologically impaired;

- The services are of a level of complexity and sophistication or the condition of the individual must be of a nature that the services can only be performed by a clinical psychologist or physician experienced in the administration of neuropsychological assessments and licensed by the Virginia Board of Medicine;

- Cognitive rehabilitation therapy services may be provided by occupational therapists, speech-language pathologists, and master's level psychologists with experience working with the neurologically impaired when provided under a plan of care/treatment plan recommended and coordinated by a physician or clinical psychologist licensed by the Virginia Board of Medicine. The plan of care/treatment plan must be prepared with the assistance and input of any specialist who may be called upon to provide services pursuant to the plan.

- The licensed clinical psychologist or the physician must provide supervision of the SLP, OT, and/or the master's level psychologist. The plan of care must be reviewed by the licensed clinical psychologist or the physician with the treating therapist and revised as needed, but at least every 30 days. When the individual no longer requires therapy services, the licensed

therapist must complete a discharge summary.

When the treating therapist is working with the individual, if consultation is needed, the licensed supervising psychologist or the physician must be available or accessible. Evidence of the supervisory visit must be documented at least every 30 days in the medical record. The supervisory documentation shall include review of the plan of care and any adjustments or revisions to the patient goals, as needed. The supervisory visit review note must be signed, titled and fully dated by the supervising psychologist or the physician.

- The cognitive rehabilitation services must be an integrated part of the total individual care plan and must relate to information processing deficits that are a consequence of and related to a neurologic event;

- The cognitive rehabilitation services include activities to improve a variety of cognitive functions such as orientation, attention/concentration, reasoning, memory, discrimination, and behavior; and

- The services must be provided with the expectation, based on the assessment made by the physician of the individual's rehabilitation potential, that the condition of the individual will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis.

Psychology, Social Work, and Therapeutic Recreation Services

These services provided to an individual must meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan ordered by a physician;

- The services must be of a level of complexity and sophistication or the condition of the individual must be of a nature that the services can only be performed by:

- Psychology - a qualified clinical psychologist (Ph.D. or Psy.D.), or by a licensed clinical social worker (LCSW), or a licensed professional counselor (LPC); or a clinical nurse specialist-psychiatric, all licensed and certified by the appropriate Board under the Virginia Department of Health Professions.
- Social Work - a qualified licensed social worker as required by the Virginia Department of Health Professions, Board of Social Work.
- Therapeutic Recreation - a certified therapeutic recreation specialist (CTRS) with the National Council for Therapeutic Recreation at the professional level.

- The services must be provided with the expectation, based on the assessment made by the physician that the condition of the individual will improve significantly in a reasonable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis;

- The services must be specific and provide effective treatment for the individual's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable; and
- When the individual no longer requires therapy services, the discipline providing services must complete a discharge summary.

Prosthetic and Orthotic Services and Other Equipment

Prosthetic Devices

Prosthetic services include prosthetic devices that replace all or part of an external body part and services necessary to design the device, including measuring, fitting, and instructing the individual in its use. Prosthetic arms, legs, breast(s) and their supportive devices are covered for all Medicaid individuals, and require service authorization by the DMAS service authorization contractor.

For further instructions, refer to the “Coverage and Limitations” section in Chapter IV of the *Prosthetic Device Manual* located on the DMAS Medicaid Web Portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal .

Orthotic Devices

Orthotic device services include devices that support or align extremities to prevent or correct abnormalities or improve functioning and services necessary to design the device, including measuring, fitting, and instructing the individual in its use.

Items made for the individual by an occupational therapist, including splints, slings, and any normally stocked supplies, are part of the cost of the DMAS approved outpatient rehabilitation visit. These items are billed as ancillary charges on the UB-92, HCFA- 1450 - Universal Claim Form.

Orthotics, including braces, splints, and supports, are not covered items for the general Adult Medicaid population (age 21 and over) under the Durable Medical Equipment and Supplies program, with the exception of the Intensive Rehabilitation program as described below.

Intensive Rehabilitation Program – Orthotic Devices

Coverage for both adults and children is available for medically necessary orthotics when recommended as part of an approved intensive inpatient rehabilitation program (including CORF), and when all of the following DME criteria are satisfied via adequate and verifiable documentation which must include:

- Ordered by the practitioner on the DMAS-352 (CMN – Certificate of Medical Necessity);

- Directly and specifically related to an active, written, and practitioner-approved rehabilitation treatment or discharge plan;

- Based upon a practitioner's assessment of the individual's rehabilitation potential, where the individual's condition will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved functional state of maintenance; and

- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational).

NOTE: For further instructions on orthotic coverage, refer to Chapter IV of the *DME and Supplies Manual* located on the DMAS Medicaid Web Portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

EPSDT – Early Periodic Screening Diagnosis and Treatment Program (For Children Under 21 Years of Age)

All medically necessary orthotics are covered for children under the age of 21 years. The same program guidelines, as identified in the above paragraph, apply to this category.

Other Medical Equipment Needs

Durable medical equipment (DME) and supplies required during the rehabilitation stay are included in the per diem rate, and entered on the rehabilitation hospital bill as ancillary services.

Durable Medical Equipment required for in-home use or to facilitate the individual's discharge home or discharge to an Adult Living Facility (ALF) may be covered under the DME and Supplies program. Refer to the DME and Supplies Manual on the DMAS Medicaid web portal. Chapter IV of the DME Manual lists covered services and limitations and the numerous appendices list the covered equipment and supplies.

For individuals who previously resided in a nursing facility or will be discharged from the hospital to a nursing facility, refer to the *Nursing Facility Manual*, Chapter IV, on the DMAS Medicaid Web Portal for DME coverage guidelines.

Outpatient Rehabilitation Services

The outpatient rehabilitation program criteria and policy guidelines can be found in the *Virginia Administrative Code*, 12 VAC 30-50-200 and 12 VAC 30-60-150. Effective January 1, 2016, these two sets of outpatient rehabilitation regulations were revised. The following outpatient rehabilitation regulations: 12 VAC 30-130-10, 15, 20, 30, 40, 42, 50, and 60 were repealed as they were repetitive, outdated, or obsolete. Rehabilitation providers have a responsibility to know the regulatory requirements for rehabilitation.

Definition of an Outpatient Rehabilitation Therapy Visit

An outpatient therapy visit is the treatment session in which a rehabilitation therapist provides the individual services prescribed by a physician or other licensed practitioner of the healing arts. Reimbursement is made on a per visit basis. The furnishing of any services by a rehabilitation therapist on a particular day or a particular time of day constitutes a visit. For example, if both a physical therapist and an occupational therapist furnish services on the same day, this constitutes two visits - one each of physical therapy and occupational therapy. If a therapist furnishes several modalities/interventions during a visit, this constitutes only one visit. However, if a therapist provides two distinctly separate therapy visits/sessions during the same day (e.g., a morning session and an afternoon session), this would constitute two visits.

Combined visits by more than one therapist cannot be billed as separate visits if the goal(s) of the therapists is the same for that visit (e.g., two therapists are required to perform a single procedure). The overall goal(s) of the sessions determines how the visit can be billed.

Group Therapy: Medicaid will reimburse for group therapy, regardless of payer source, for a minimum of two but no more than six (6) individuals.

Admission Criteria

DMAS requires the following for Outpatient Rehabilitation Services:

- The participant must meet InterQualÒ criteria upon admission and for continued services. The InterQualÒ criteria may be obtained through McKesson Health Solutions LLC.
- For the current McKesson mailing address, phone and fax numbers and the InterQualÒ web site address, refer to Appendix D. of this manual, which contains the service authorization information.

In addition to the InterQualÒ criteria requirements, eligibility for general outpatient rehabilitative services is based on the individual's medical need for one or more of the following covered services: physical therapy, occupational therapy, or speech-language pathology services. A physician or other licensed practitioner of the healing arts, such as a nurse practitioner or a physician assistant, within the scope of his/her practice under State law, must prescribe these services.

Rehabilitation services is medically prescribed treatment for improving or restoring functions that have been impaired by illness or injury, or where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Rehabilitation services for speech impairments secondary to developmental delays, autism, and other related communication disorders are also covered services.

Admissions for evaluation and/or training solely for vocational or educational purposes or for developmental or behavioral assessments are not covered services.

Any one of these therapy services (PT, OT or Speech) may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service. Medicaid covers general outpatient rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals, nursing facilities, home health agencies, and rehabilitation agencies. All providers must have a provider agreement with the Department of Medical Assistance Services (DMAS).

All practitioners and providers of services shall be required to meet state and federal licensing and certification requirements. Services not specifically documented in the individual's medical record as having been rendered shall be deemed not to have been rendered, and no payment shall be provided.

Providers of Service

A physician or other licensed practitioner of the healing arts, such as a nurse practitioner or a physician assistant, within the scope of his/her practice under State law, may order services, develop the plan of care, and complete physician initial certification and recertifications under the direct supervision of a physician. If therapy services are ordered by a practitioner of the healing arts other than a

physician, supervisory requirements must be performed by a physician as required by the Virginia Department of Health Professions regulations. (Virginia State Code § 54.1-2957.02; 42 Code of Federal Regulations, 440.130 (d), 485.711)

Therapist Qualifications and Therapy Modalities – Refer to Intensive Rehab Section

The qualifications for physical therapists, occupational therapists, and speech-language pathologists, as well as therapy modalities and treatment procedures, are defined in the ***Intensive Rehabilitation section*** of this chapter. The same qualifications apply to outpatient rehabilitation providers. Refer to this section for more information. The same section also includes supervision documentation requirements for therapy assistants as does Chapter VI of this manual.

Guidelines for Initiating and Continuing Therapy

[Applicable for <u>both</u> Inpatient & Outpatient Rehabilitation]

- *<u>Maintenance Therapy</u>* - Interpreted as: 1) the point in therapy where the individual demonstrates no further significant improvement, *<u>or</u>* 2) the skills of a qualified rehabilitative therapist are not required to carry out an activity or a home program to maintain functioning at the level to which it has been restored. These services are not covered by Medicaid.
- *<u>Improvement of Function</u>* – Interpreted as rehabilitative therapy designed to improve function and based on an expectation that: 1) the therapy will result in a significant improvement in an individual's level of functioning within a reasonable period of time; 2)there is a valid expectation of improvement at the time the rehabilitative therapy program is implemented; and 3) the services would be recognized even though the expectation may not be realized.

For continued intensive rehabilitation services, the individual must demonstrate an ability to actively participate in goal-related therapeutic interventions developed by the interdisciplinary team and demonstrate progression toward the established goals.

Co-Payments (Rehab)

Some Medicaid individuals must pay a small amount for certain services. This is called a co-payment. For the purpose of co-payments, a visit is defined as a patient

encounter in the same place of treatment, by the same provider, on the same day, regardless of the number of procedures or visits performed during the same day (*Note the outpatient rehabilitation exception listed below).

The following individuals do not pay a co-payment for services covered by Medicaid:

- Children younger than age 21,
- Individuals receiving institutional or community-based long-term care services (patient pay may be applicable), and
- Individuals in hospice programs.

Medicaid does not charge a co-payment for the following services:

- Emergency services (including dialysis treatments)
- Pregnancy-related services
- Family-planning services
- Emergency room services

Medicaid charges co-payments for individuals age 21 and older for the following services:

Service	**Co-Payment Amount**
Inpatient Hospital (includes Rehab Hospital)	$100.00 per admission
Rehabilitation Service (includes Outpatient Rehabilitation and CORF) *	$3.00 per visit
Outpatient Hospital Clinic	$3.00 per visit
Clinic Visit	$1.00 per visit
Physician Office Visit	$1.00 per visit
Other Physician Visit	$3.00 per visit
Eye Examination	$1.00 per examination
Prescription	$3.00 per for brand name $1.00 for generic
Home Health Visit	$3.00 per visit

*Outpatient rehabilitation service (including CORF): * $3.00 co-pay per visit (if more than one therapy visit provided per day, the individual is responsible for one $3.00 co-pay)

Services to an individual cannot be denied solely because of his or her inability to pay any applicable co-payment charge. This does not relieve the individual of the responsibility to pay, nor does it prevent the provider from attempting to collect any applicable co-payment from the individual.

Coordination of Rehabilitation Services

The purpose of coordination of services is to maximize therapy benefits for the individual. Coordination of services between treating therapists should be done when an individual receives therapies from two separate rehabilitation providers (i.e., school and after-school therapies). Coordination of services allows two treatment therapists to guarantee maximum benefit of services for the individual is achieved based on the treatment plans. When two separate rehabilitation providers are not coordinating services, the treatment plans may be in conflict with the desired individual's outcome.

Therapists do have a professional responsibility to keep physicians and parents/caregivers informed of each individual's rehabilitation progress. Coordination of services will be reviewed by the DMAS Service Authorization (SA) contractor through the SA process and by DMAS for compliance during utilization review activities.

Categorization of Two Subgroups: Acute vs. Non-Acute Conditions (Rehab)

There are two subgroups in general outpatient rehabilitation: acute conditions and long- term, non-acute conditions.

- **Acute conditions** are defined as those conditions which are expected to require rehabilitative services for a duration of less than twelve (12) months, and in which progress toward established goals is likely to occur frequently.
- **Long-term, non-acute conditions** are defined as those conditions which are expected to require rehabilitative services for a duration of greater than twelve (12) months, and in which progress toward established goals is likely to occur slowly.

If the individual is appropriate for the acute sub-group, requiring rehabilitative services for less than twelve (12) months, a physician re-certification (renewal of orders and plan of care/treatment plan) is required at least every sixty (60) days. Any initial plan of care/treatment plan or periodic renewal written by the qualified

therapist must be signed and dated by the physician within 21 days of implementation date of the plan.

If the individual is appropriate for the long-term, non-acute sub-group, requiring rehabilitative services for greater than twelve (12) months, a physician re-certification (renewal of orders and plan of care/treatment plan) is required at least annually. The physician must sign and date the order/plan of care/treatment plan at the time of review/renewal prior to the initiation of the continuation of service.

Defining a condition as acute or as long-term, non-acute, is not based on an individual's diagnosis. Defining the condition is based on the length of time services are medically justified. The requirement for the development of an appropriate and realistic plan of care/treatment plan remains unchanged. Plans of care/treatment plans must still include measurable, long-term and short term goals with anticipated dates of achievement. Plans of care/treatment plans must be renewed by the physician at any time long term goals are achieved or are in need of revision, regardless of the subgroup categorization of the individual.

Discharge Planning (Rehab)

Discharge planning must be an integral part of the treatment plan and developed at the time treatment is initiated. The plan shall identify an anticipated safe and effective maintenance program, if applicable, and the individual's functional status and discharge outcomes. The individual or their legal representative should be involved in the discharge planning process.

Home Therapies (Rehab)

Licensure requirements in the State of Virginia allow only agencies that are licensed as home care organizations may provide services in the home (Code of Virginia, 32.1-162.9). An exception is providers of services for children enrolled with the Early Intervention Services (EIS) program (Part C of IDEA); they are not required to be licensed as home care organizations. [Code of Virginia, Section 2.2-5308]

If an outpatient rehabilitation agency is contracting with a school district to provide rehabilitation services to special education Medicaid children in accordance with the IEP (Individualized Education Program), which identifies home-based instruction and rehabilitation therapy services, then home therapies may be provided by the outpatient rehabilitation provider as long as the provider is licensed as a home health care agency. [8 VAC (Virginia Administrative Code) 20-131-180 and 8 VAC 20-80-10]

School districts, under contract with outpatient rehabilitation providers must bill

DMAS for all rehabilitation services provided to Medicaid individuals with an IEP. Refer to the Medicaid Local Education Agency (LEA) Manual, Chapter IV, for more information regarding school rehabilitation coverage and limitations. The LEA Manual is on the Medicaid web portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Therapies Provided in Nursing Facilities (Rehab)

DMAS provides direct reimbursement to enrolled rehabilitation providers for outpatient therapies rendered to individuals residing in nursing facilities. This reimbursement shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the nursing facility or any other available source. In addition, it shall in no way diminish any obligation of the nursing facility to provide its individuals such services, as set forth in any applicable provider agreement. If a physician (or other licensed practitioner) order exists for therapies, therapies must be provided as ordered. For nursing facilities that have therapist as a part of their staff, this section is not applicable. Reasonable and necessary administrative costs will be considered under the cost settlement process for the nursing facility.

Rehabilitative Services in ICF/IID Facilities

DMAS provides direct reimbursement to enrolled rehabilitation providers for outpatient therapies rendered to individuals residing in an intermediate care facility for individuals with an intellectual disability (ICF/IID). This reimbursement shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the facility or any other available source. If rehabilitation therapists provide facility staff with instruction or consultation, this service cannot be billed to Medicaid. However, these services may be considered an administrative cost and may be billed to the ICF/IID. Reasonable and necessary administrative costs will be considered under the cost settlement process for the ICF/IID facility.

Rehabilitation Therapy - Specific Modalities

The rehabilitation treatment plan must address significant improvement of functional ability, mobility, and endurance, and not simply performing repetitious exercises or maintenance activities.

There are multiple types of modalities offered as part of a treatment plan that requires the skills of a licensed therapist and as described above, that would be an appropriate treatment plan. For a modality example, if an individual is receiving “ground” or “land” therapy in the rehabilitation agency, in addition to participation in pool therapy, this would be a rehabilitative covered service. However, water aerobics

classes are not rehabilitation covered service because they do not require the skills of a licensed therapist and are to "maintain" an individual at a certain level of function attained.

Another modality example is "hippotherapy", which is offered to an individual while riding a horse that addresses agility, gross and fine motor skills, balance and coordination. This is another modality example for a treatment plan that requires the skills of a licensed therapist.

For information regarding Day Feeding Programs or information regarding EPSDT programs for those children under age 21, refer to the DMAS agency web site located at: http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx.

Discharge/Termination from Services (Rehab)

[Applicable for both Inpatient & Outpatient Rehabilitation]

Rehabilitation services must be considered for termination, regardless of the service authorized or approved length of stay, when further progress toward the established rehabilitation goal is unlikely or further rehabilitation treatment can be achieved in a less intensive setting, such as in nursing facilities, home and community based settings, home health agencies, and/or maintenance program.

Intensive/Inpatient rehabilitation services must be considered for termination when any one of the following conditions is met:

- No further potential for improvement is demonstrated. The specialized knowledge and skills of a licensed/registered rehabilitative therapist are no longer required for safe and effective provision of such rehabilitation services. The individual has reached his/her maximum progress and a safe and effective maintenance program has been developed;
- There is limited motivation on the part of the individual or caregiver;
- The individual has an unstable condition that affects his/her ability to participate in an intensive/inpatient comprehensive rehabilitative plan;
- Progress toward an established goal or goals cannot be achieved within a reasonable period of time;
- The established goals serve no purpose to increase functional or cognitive capabilities; or
- The service can be provided by someone other than a licensed or

registered/certified rehabilitation professional.

Billing Instructions (Rehab)

The purpose of this chapter is to explain the documentation procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- **Billing Procedures** - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

Electronic Submission of Claims

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent,

Conduent:

Phone: (866)-352-0766

Fax number: (888)-335-8460

Website: https://vamedicaid.dmas.virginia.gov/edi or by mail

Conduent:

EDI Coordinator

Virginia Medicaid Fiscal Agent

P.O. Box 26228

Richmond, Virginia 23260-6228

Billing Instructions: Direct Data Entry

As part of the 2011 General Assembly Appropriation Act - 300H which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system. DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.vamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider.

(This Section is under Review - March 2022)

Timely Filing

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the

patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims – Denied claims must be submitted and processed **on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits).

Accident Cases - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursement.

Other Primary Insurance - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursements. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Other Insurance - The member can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

Billing Instructions: Billing Invoices (Rehab)

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below are the two billing invoices to be used:

- Health Insurance Claim Form, CMS-1500 (02-12)
- Health Insurance Claim Form, CMS-1450 UB-04

If submitting on paper, the requirement to submit claims on an original CMS-1500 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid

Automated Crossover Claims Processing (Rehab)

Most claims for dually eligible members are automatically submitted to DMAS. The Medicare claims processor will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as "crossovers" since the claims are automatically crossed over from Medicare to Medicaid.

DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov

Requests for Billing Materials (PP)

Health Insurance Claim Form CMS-1500 (02-12) and (UB-04)

The CMS-1500 (02-12) and CMS-1450 (UB-04) are universally accepted claim forms that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402

(202) 512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (02-12)

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at

our fiscal agent's website: www.virginiamedicaid.dmas.virginia.gov.

Claim Inquiries and Reconsideration

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long-distance (toll-free)

Member verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800- 884-9730	Toll-free throughout the United States
1-804- 965-9732	Richmond and Surrounding Counties
1-804- 965-9733	Richmond and Surrounding Counties

Member verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

Billing Procedures (Hospital)

Hospitals and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied, in correct national form and format, or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services

P.O. Box 27443

Richmond, Virginia 23261-7443

Or

Department of Medical Assistance Services

CMS Crossover

P. O. Box 27444

Richmond, Virginia 23261-7444

Billing Instructions: Electronic Filing Requirements

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)

276/277 Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)

277 - Unsolicited Response (5010)

820 - Premium Payment for Enrolled Health Plan Members (5010)

834 - Enrollment/ Disenrollment to a Health Plan (5010)

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

NCPDP - National Council for Prescription Drug Programs Batch (5010)

NCPDP - National Council for Prescription Drug Programs POS (5010) Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

All 5010/D.0 Companion Guides are available on the web portal: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides or contact EDI Support at 1-866-352-0766 or Virginia.EDISupport@conduent.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov.

Billing Instructions: ClaimCheck

Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. Effective January 1, 2014, all outpatient hospital claims will be subject the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

- **PTP Edits**
  CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP

category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. Note: Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

- **MUE Edits**
  DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, potentially resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim.
- **Exempt Provider Types**
  DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB), Federal Health Center (FQHC),Rural Health Clinics (RHC), Schools and Health Departments. These are the only providers exempt from the NCCI/editing process. All other providers billing on the CMS 1500 will be subject to these edits.
- **Service Authorizations**
  DMAS has received approval from CMS to exempt specific CPT/HCPCS codes which require a valid service authorization. These codes are exempt from the MUE edits however, they are still subject to the PTP and ClaimCheck edits.
- **Modifiers**
  Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation,DMAS now only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of “1”or “0” in the listing of the NCCI PTP column code. If the column one, column two code combination has a modifier indicator of “1”, a modifier is allowed and both codes will pay. If the modifier indicator is “0”, the modifier is not allowed and the column two code will be denied. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient’s medical record must contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

  Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 –E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78,

79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

RECONSIDERATION

Providers that disagree with the action taken by a ClaimCheck/NCCI edit may request a reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Payment Processing Unit, Claim Check

Division of Program Operations

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

There is a 30-day time limit form the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

Billing Instructions Reference for Services Requiring Service Authorization

Please refer to the “Service Authorization” section in Appendix D of this manual.

Billing Instructions: Cost Settlement (rehab)

DMAS publishes, on the DMAS Internet hompage, the Rehabilitation Agency Administrator/Owner Compensation Limitations annually which are part of Medicaid’s reasonable cost provisions.

Clifton Gunderson P.L.L.C conducts the desk review and settlement of Medicaid cost reports. Clifton Gunderson follows the same policies and procedures that have applied to DMAS’ performance of these activities. Send cost reports directly to:

Clifton
Gunderson
P.L.L.C. 4144-B
Innslake Drive

Glen Allen, VA
23060-3387
804-270-2200
(telephone)

804-270-2311 (facsimile)

If a payment to the Medicaid Program is due with the cost report, the payment/check, but not the cost report, must be sent directly to DMAS at the following address:

Department of Medical Assistance
Services Cashiering Unit

Division of Fiscal and
Procurement 600 East
Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia regulations require cost reports to be filed five months after the provider's fiscal year end. If a cost report is not submitted to Medicaid at the end of the five-month period, there is no grace period, and the provider's rate will be reduced to zero immediately.

Private rehabilitation agencies will no longer have to submit cost reports for periods after June 30, 2009.

DMAS will continue to reimburse Community Services Boards and state agencies their allowed cost for rehabilitation services. Community Services Boards and state agencies still must change their billing to the CMS-1500 using CPT codes and they will be paid initially according to the above fee schedule on the remittance. However, DMAS will make quarterly interim payments to approximate reimbursement at cost and will settle final reimbursement based on a cost report.

If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1(804) 780-0076.

Requests for information or questions concerning the ordering of forms, call: 1 (804) 780-0076.

Medicaid Rehabilitation Facility Billing Invoices

The use of the appropriate billing invoice is necessary for payment to be made. The accepted billing forms are:

- Health Insurance Claim Form, CMS-1450, UB 04, beginning with dates of service on or after July 1, 2009 this form will only be accepted for inpatient rehabilitative services or outpatient general acute care hospital rehabilitative services. It will not be accepted for claims by Rehabilitative Agencies or CORF providers.

- Health Insurance Claim Form, CMS-1500 (02-12) – will be mandated for Rehabilitative Agencies and CORF providers beginning with dates of service on or after July 1, 2009

- Title XVIII (Medicare) Deductible and Coinsurance Invoice – DMAS-30, revised 5/06

- Title XVIII (Medicare) Deductible and Coinsurance Invoice - Adjustment/Void Invoice – DMAS-31, revised 5/06

Billing Instructions: Instructions for Completing the UB-04 CMS-1450 Claim Form

Locator		Instructions
1	**Provider Name, Address, Telephone Required**	**Provider Name, Address, Telephone -** Enter the provider's name, complete mailing address and telephone number of the provider that is submitting the bill and which payment is to be sent. Line 1. Provider Name Line 2. Street Address Line 3. City. State, and 9 digit Zip Code Line 4. Telephone; Fax; Country Code

2	**Pay to Name & Address Required if Applicable**	**Pay to Name & Address -** Enter the address of the provider where payment is to be sent, if different than Locator 1. NOTE: DMAS will need to have the 9 digit zip code on line three, left justified for adjudicating the claim if the provider has provided only one NPI and the servicing provider has multiple site locations for this service.
3a	**Patient Control Number Required**	**Patient Control Number -** Enter the patient's unique financial account number which does not exceed 20 alphanumeric characters.
3b	**Medical/Health Record Required**	**Medical/Health Record -** Enter the number assigned to the patient's medical/health record by the provider. This number cannot exceed 24 alphanumeric characters.
4	**Type of Bill Required**	Type of Bill - Enter the code as appropriate. Valid codes for Virginia Medicaid are: 0111 Original Inpatient Hospital Invoice 0112 Interim Inpatient Hospital Claim Form* 0113 Continuing Inpatient Hospital Claim Invoice* 0114 Last Inpatient Hospital Claim Invoice* 0117 Adjustment Inpatient Hospital Invoice 0118 Void Inpatient Hospital Invoice 0131 Original Outpatient Invoice 0137 Adjustment Outpatient Invoice 0138 Void Outpatient Invoice **These below are for Medicare Crossover Claims Only** 0721 Clinic - Hospital Based or Independent Renal Dialysis Center 0727 Clinic - Adjustment-Hospital Based or Independent Renal Dialysis Center 0728 Clinic - Void - Hospital Based or Independent Renal Dialysis Center * The proper use of these codes (see the National Uniform Billing Manual) will enable DMAS to reassemble inpatient acute medical/surgical hospital cycle-billed claims to form DRG cases for purposes of DRG payment calculations and cost settlement.
5	Federal Tax Number Not Required	Federal Tax Number - The number assigned by the federal government for tax reporting purposes

6	**Statement Covered Period Required**	**Statement Covered Period -** Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day. For hospital admissions, the billing cycle for general medical surgical services has been expanded to a minimum of 120 days for both children and adults except for psychiatric services. Psychiatric services for adults' remains limited to the 21 days. Interim claims (bill types 0112 or 0113) submitted with less than 120 day will be denied. Bill type 0111 or 0114 submitted with greater than 120 days will be denied. Outpatient: spanned dates of service are allowed in this field. See block 45 below.
7	Reserved for assignment by the NUBC	Reserved for assignment by the NUBC **NOTE: This locator on the UB 92 contained the covered days of care. Please review locator 39 for appropriate entry of the covered and non-covered days.**
8	**Patient Name/Identifier Required**	**Patient Name/Identifier -** Enter the last name, first name and middle initial of the patient on line b. Use a comma or space to separate the last and first name.
9	Patient Address	Patient Address - Enter the mailing address of the patient. a. Street address b. City c. State d. Zip Code (9 digits) e. Country Code if other than USA
10	**Patient Birthdate Required**	**Patient Birthdate –** Enter the date of birth of the patient.
11	**Patient Sex Required**	**Patient Sex –** Enter the sex of the patient as recorded at admission, outpatient or start of care service. M = male; F = female and U = unknown
12	**Admission/Start of Care Required**	**Admission/Start of Care –** The start date for this episode of care. For inpatient services, this is the date of admission. For all other services, the date the episode of care began.
13	**Admission Hour Required**	**Admission Hour –** Enter the hour during which the patient was admitted for inpatient or outpatient care. **Note**: Military time is used as defined by NUBC.

<table>
<tr>
<td>14</td>
<td>Priority (Type) of Visit Required</td>
<td>Priority (Type) of Visit – Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS are:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1</td><td>Emergency – patient requires immediate intervention for severe, life threatening or potentially disabling condition</td></tr>
<tr><td>2</td><td>Urgent – patient requires immediate attention for the care and treatment of physical or mental disorder</td></tr>
<tr><td>3</td><td>Elective – patient’s condition permits adequate time to schedule the services</td></tr>
<tr><td>4</td><td>Newborn</td></tr>
<tr><td>5</td><td>Trauma – Visit to a licensed or designated by the state or local government trauma center/hospital and involving a trauma activation</td></tr>
<tr><td>9</td><td>Information not available</td></tr>
</table>
</td>
</tr>
<tr>
<td>15</td>
<td>Source of Referral for Admission or Visit Required</td>
<td>Source of Referral for Admission or Visit – Enter the code indicating the source of the referral for this admission or visit.
Note: Appropriate codes accepted by DMAS are:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1</td><td>Physician Referral</td></tr>
<tr><td>2</td><td>Clinic Referral</td></tr>
<tr><td>4</td><td>Transfer from Another Acute Care Facility</td></tr>
<tr><td>5</td><td>Transfer from a Skilled Nursing Facility</td></tr>
<tr><td>6</td><td>Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility)</td></tr>
<tr><td>7</td><td>Emergency Room</td></tr>
<tr><td>8</td><td>Court/Law Enforcement - Admitted Under Direction of a Court of Law, or Under Request of Law Enforcement Agency</td></tr>
<tr><td>9</td><td>Information not available</td></tr>
<tr><td>D</td><td>Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr><td>16</td><td>Discharge Hour Required</td><td>Discharge Hour – Enter the code indicating the discharge hour of the patient from inpatient care. Note: Military time is used as defined by NUBC</td></tr>
<tr><td>17</td><td>Patient Discharge Status Required</td><td>Patient Discharge Status – Enter the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (statement covered period, locator 6). Note: If the patient was a one-day stay, enter code "01". Appropriate codes accepted by DMAS are:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>01</td><td>Discharged to Home</td></tr>
<tr><td>02</td><td>Discharged/transferred to Short term General Hospital for Inpatient Care</td></tr>
<tr><td>03</td><td>Discharged/transferred to Skilled Nursing Facility</td></tr>
<tr><td>04</td><td>Discharged/transferred to Intermediate Care Facility</td></tr>
<tr><td>05</td><td>Discharged/transferred to Another Facility not Defined Elsewhere</td></tr>
<tr><td>06</td><td>Discharged/transferred to home under care of organized home health service</td></tr>
<tr><td>07</td><td>Left Against Medical Advice or Discontinued Care</td></tr>
<tr><td>20</td><td>Expired</td></tr>
<tr><td>30</td><td>Still a Patient</td></tr>
<tr><td>50</td><td>Hospice – Home</td></tr>
<tr><td>51</td><td>Hospice – Medical Care Facility</td></tr>
<tr><td>61</td><td>Discharged/transferred to Hospital Based Medicare Approved Swing Bed</td></tr>
<tr><td>62</td><td>Discharged/transferred to an Inpatient Rehabilitation Facility</td></tr>
<tr><td>63</td><td>Discharged/transferred to a Medicare Certified Long Term Care Hospital</td></tr>
<tr><td>64</td><td>Discharged/transferred to Nursing Facility Certified under Medicaid but not Medicare</td></tr>
<tr><td>65</td><td>Discharged/transferred to Psychiatric Hospital of Psychiatric Distinct Part Unit of Hospital</td></tr>
<tr><td>66</td><td>Discharged/Transferred to a Critical Access Hospital (CAH)</td></tr>
</table></td></tr>
</table>

<table>
<tr><td>18 thru 28</td><td>Condition Codes Required if applicable</td><td>Condition Codes – Enter the code(s) in alphanumeric sequence used to identify conditions or events related to this bill that may affect adjudication.
Note: DMAS limits the number of condition codes to maximum of 8 on one claim. These codes are used by DMAS in the adjudication of claims:<table><tr><th>Code</th><th>Description</th></tr><tr><td>39</td><td>Private Room Medically Necessary</td></tr><tr><td>40</td><td>Same Day Transfer</td></tr><tr><td>A1</td><td>EPSDT</td></tr><tr><td>A4</td><td>Family Planning</td></tr><tr><td>A5</td><td>Disability</td></tr><tr><td>A7</td><td>Inducted Abortion Danger to Life</td></tr><tr><td>AA</td><td>Abortion Performed due to Rape</td></tr><tr><td>AB</td><td>Abortion Performed due to Incest</td></tr><tr><td>AD</td><td>Abortion Performed due to a Life Endangering Physical Condition</td></tr><tr><td>AH</td><td>Elective Abortion</td></tr><tr><td>AI</td><td>Sterilization</td></tr></table></td></tr>
<tr><td>29</td><td>Accident State</td><td>Accident State – Enter if known the state (two digit state abbreviation) where the accident occurred.</td></tr>
<tr><td>30</td><td>Crossover Part A Indicator</td><td>Note: DMAS is requiring for Medicare Part A crossover claims that the word “CROSSOVER” be in this locator</td></tr>
<tr><td>31 thru 34</td><td>Occurrence Code and Dates Required if applicable</td><td>Occurrence Code and Dates – Enter the code and associated date defining a significant event relates to this bill. Enter codes in alphanumeric sequence.</td></tr>
<tr><td>35 thru 36</td><td>Occurrence Span Code and Dates Required if applicable</td><td>Occurrence Span Code and Dates – Enter the code and related dates that identify an event that relating to the payment of the claim. Enter codes in alphanumeric sequence.</td></tr>
<tr><td>37</td><td>TDO or ECO Indicator Required if applicable</td><td>Note: DMAS is requiring that for claims to be processed by the Temporary Detention Order (TDO) or by Emergency Custody Order (ECO) program, providers will enter TDO or ECO in this locator.</td></tr>
<tr><td>38</td><td>Responsible Party Name and Address</td><td>Responsible Party Name and Address – Enter the name and address of the party responsible for the bill</td></tr>
</table>

39 thru 41	**Value codes and Amount Required**	**Value Codes and Amount -** Enter the appropriate code(s) to relate amounts or values to identify data elements necessary to process this claim. **Note:** DMAS will be capturing the number of covered or noncovered day(s) or units for inpatient and outpatient service(s) with these required value codes: *80* Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims. *81* Enter the number of non-covered days for inpatient hospitalization **Note:** The format is digit: do not format the number of covered or non-covered days as dollar and cents **AND** One of the following codes must be used to indicate the coordination of third party insurance carrier benefits: *82* No Other Coverage *83* Billed and Paid (enter amount paid by primary carrier) *85* Billed Not Covered/No Payment For Part A Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above: *A1* Deductible from Part A *A2* Coinsurance from Part A Other codes may also be used if applicable. The a, b, or c line containing this above information should Cross Reference to Payer Name (Medicaid or TDO) in Locator 50 A, B, C.
42	**Revenue Code Required**	**Revenue Codes -** Enter the appropriate revenue code(s) for the service provided. Note: • Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order, • Claims with multiple dates of services should indicate the date of service of each procedure performed on the revenue line, • DMAS has a limit of five pages for one claim, • The Total Charge revenue code (0001) should be the last line of the last page of the claim, and • See the Revenue Codes list under “Exhibits” at the end of this chapter for approved DMAS codes.

43	**Revenue Description Required**	**Revenue Description -** Enter the standard abbreviated description of the related revenue code categories included on this bill. For Outpatient Claims, when billing for Revenue codes 0250-0259 or 0630-0639, you must enter the NDC qualifier of N4, followed by the 11-digit NDC number, and the unit of measurement followed by the metric decimal quantity or unit. Do not enter a space between the qualifier and NDC. Do not enter hyphens or spaces within the NDC. The NDC number being submitted must be the actual number on the package or container from which the medication was administered. Unit of Measurement Qualifier Codes: F2 – International Units GR – Gram ML – Milliliter UN – Unit Examples of NDC quantities for various dosage forms as follows: a. Tablets/Capsules – bill per UN b. Oral Liquids – bill per ML c. Reconstituted (or liquids) injections – bill per ML d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit) e. Creams, ointments, topical powders – bill per GR f. Inhalers – bill per GR Any spaces unused for the quantity should be left blank
44	**HCPCS/Rates/ HIPPS Rate Codes Required (if applicable) Modifier**	**HCPCS/Rates/HIPPS Rate Codes -** Inpatient: Enter the accommodation rate. For Ambulatory Surgical Centers, enter the CPT or HCPCS code on the same line that the revenue code 0490 is entered. Outpatient: For outpatient claims, the applicable HCPCS/CPT procedure code must appear in this locator with applicable modifiers.. Invalid CPT/HCPCS codes will result in the claim being denied. Providers participating in the 340B drug discount program must submit each drug line with modifier UD.

45	**Service Date Required**	**Service Date -** Enter the date the outpatient service was provided. Outpatient: Each line must have a date of service. Claims with multiple dates of service must indicate the date of service of each procedure performed on the corresponding revenue line. To be separately reimbursed for each visit- example chemotherapy, dialysis, or therapy visits- each revenue line should include the date of service for these series billed services.
46	**Service Units Required**	**Service Units -** Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit). Enter the HCPCS units when a HCPCS code is in locator 44. Observation units are required.
47	**Total Charges Required**	**Total Charges -** Enter the total charge(s) for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non-covered charges. Note: Use code “0001” for TOTAL.
48	**Non-Covered Charges Required if applicable**	**Non-Covered Charges -** To reflect the non-covered charges for the primary payer as it pertains to the related revenue code.
49	Reserved	Reserved for Assignment by the NUBC.
50	**Payer Name AC. Required**	**Payer Name -** Enter the payer from which the provider may expect some payment for the bill. *A* Enter the primary payer identification. *B* Enter the secondary payer identification, if applicable. *C* Enter the tertiary payer if applicable. When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C. This also applies to the Temporary Detention and Emergency Custody Order claims.
51	Health Plan Identification Number A-C	Health Plan Identification Number - The number assigned by the health plan to identify the health plan from which the provider might expect payment for the bill. **NOTE**: DMAS will no longer use this locator to capture the Medicaid provider number. Refer to locators 56 and 57

52	Release of Information Certification Indicator A-C	Release of Information Certification Indicator - Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.
53	Assignment of Benefits Certification Indicator A-C	Assignment of Benefits Certification Indicator - Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.
54	**Prior Payments – Payer A,B,C Required (if applicable)**	**Prior Payments Payer –** Enter the amount the provider has received (to date) by the health plan toward payment of this bill. **NOTE:** Long-Term Hospitals and Nursing Facilities: Enter the patient pay amount on the appropriate line (a-c) that is showing Medicaid as the payer in locator 50. The amount of the patient pay is obtained via either Medicall or ARS. See Chapter I for detailed information on Medicall and ARS. **DO NOT ENTER THE MEDICAID COPAY AMOUNT**
55	Estimated Amount Due A,B,C,	Estimated Amount Due – Payer – Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).
56	**NPI Required**	**National Provider Identification –** Enter your NPI.
57A thru C	**Other Provider Identifier Required (if applicable)**	**Other Provider Identifier -** DMAS will not accept claims received with the legacy Medicaid number in this locator. For providers who are given an Atypical Provider Number (API), this is the locator that will be used. Enter the provider number on the appropriate line that corresponds to the member name in locator 50.

<table>
<tr><td>58</td><td>Insured’s Name A-C Required</td><td>INSURED'S NAME - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card.
• Enter the insured's name used by the primary payer identified on Line A, Locator 50.
• Enter the insured's name used by the secondary payer identified on Line B, Locator 50.
• Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.</td></tr>
<tr><td>59</td><td>Patient’s Relationship to Insured A-C Required</td><td>Patient’s Relationship to Insured - Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>01</td><td>Spouse</td></tr>
<tr><td>18</td><td>Self</td></tr>
<tr><td>19</td><td>Child</td></tr>
<tr><td>21</td><td>Unknown</td></tr>
<tr><td>39</td><td>Organ Donor</td></tr>
<tr><td>40</td><td>Cadaver Donor</td></tr>
<tr><td>53</td><td>Life Partner</td></tr>
<tr><td>G8</td><td>Other Relationship</td></tr>
</table></td></tr>
<tr><td>60</td><td>Insured’s Unique Identification AC Required</td><td>Insured’s Unique Identification - For lines A-C, enter the unique identification number of the person insured that is assigned by the payer organization shown on Lines A-C, Locator 50. NOTE: The Medicaid member identification number is 12 numeric digits.</td></tr>
<tr><td>61</td><td>(Insured) Group Name A-C</td><td>(Insured) Group Name - Enter the name of the group or plan through which the insurance is provided.</td></tr>
<tr><td>62</td><td>Insurance Group Number A-C</td><td>Insurance Group Number - Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.</td></tr>
</table>

63	**Treatment Authorization Code Required (if applicable)**	**Treatment Authorization Code -** Enter the 11 digits service authorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid. **Note:** The 15 digit TDO or ECO order number from the pre-printed form is to be entered in this locator.
64	**Document Control Number (DCN) Required for adjustment and void claims**	**Document Control Number –** The control number assigned to the original bill by Virginia Medicaid as part of their internal claims reference number. Note: This locator is to be used to place the original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim.
65	Employer Name (of the Insured) A-C	Employer Name (of the Insured) - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**Diagnosis and Procedure Code Qualifier Required**	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator) –** The qualifier that denotes the version of the International Classification of Diseases. Note: DMAS will only accept a 9 or 0 in this locator. 9= ICD-9-CM – Dates of service through 9/30/15, 0=ICD-10-CM – Dates of service on and after 10/1/15."
67	**Principal Diagnosis Code Required**	**Principal Diagnosis Code -** Enter the ICD diagnosis code that describes the principal diagnosis (i.e., the condition established after study to chiefly responsible for occasioning the admission of the patient for care). NOTE: Special instructions for the Present on Admission indicator below. **DO NOT USE DECIMALS.**

<table>
<tr>
<td>67A & 67A-Q</td>
<td>Present on Admission (POA) Indicator Required</td>
<td>Present on Admission (POA) Indicator – The locator for the POA is directly after the ICD diagnosis code in the red shaded field and is required for the Principal Diagnosis and the Secondary Diagnosis code . The applicable POA indicator for the principal and any secondary diagnosis is to be indicated if:
• the diagnosis was known at the time of admission, or
• the diagnosis was clearly present, but not diagnosed, until after admission took place or
• was a condition that developed during an outpatient encounter.
The POA indicator is in the shaded area.
Reporting codes are:
<table>
<tr><th>Code</th><th>Definition</th></tr>
<tr><td>Y</td><td>Yes</td></tr>
<tr><td>N</td><td>No</td></tr>
<tr><td>U</td><td>No information in the record</td></tr>
<tr><td>W</td><td>Clinically undetermined</td></tr>
<tr><td>1 or blank</td><td>Exempt from POA reporting</td></tr>
</table>
*Blank or 1 is only allowed for diagnoses excluded by CMS for the specific diagnosis code.</td>
</tr>
<tr>
<td>67 A thru Q</td>
<td>Other Diagnosis Codes Required if applicable</td>
<td>Other Diagnosis Codes Enter the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. DO NOT USE DECIMALS.</td>
</tr>
<tr>
<td>68</td>
<td>Special Note</td>
<td>Note: Facilities may place the adjustment or void error reason code in this locator. If nothing here, DMAS will default to error codes: 1052 – miscellaneous void or 1053 – miscellaneous adjustment.</td>
</tr>
<tr>
<td>69</td>
<td>Admitting Diagnosis Required</td>
<td>Admitting Diagnosis – Enter the diagnosis code describing the patient’s diagnosis at the time of admission. DO NOT USE DECIMALS.</td>
</tr>
<tr>
<td>70 a-c</td>
<td>Patient’s Reason for Visit Required if applicable</td>
<td>Patient’s Reason for Visit – Enter the diagnosis code describing the patient’s reason for visit at the time of inpatient or unscheduled outpatient registration. DO NOT USE DECIMALS.</td>
</tr>
<tr>
<td>71</td>
<td>Prospective Payment System (PPS) Code</td>
<td>Prospective Payment System – Enter the PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.</td>
</tr>
</table>

<table>
<tr><td>72</td><td>External Cause of Injury Required if applicable</td><td>External Cause of Injury - Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect. DO NOT USE DECIMALS.
Present on Admission (POA) Indicator – The locator for the POA is directly after the ICD-diagnosis code in the red shaded field and is required for the External Cause of Injury code. The POA indicator is a required field and is to be indicated if:
the diagnosis was known at the time of admission, or
the diagnosis was clearly present, but not diagnosed, until after admission took place or was a condition that developed during an outpatient encounter.
The POA indicator is in the shaded area.
Reporting codes are:
<table>
<tr><th>Code</th><th>Definition</th></tr>
<tr><td>Y</td><td>Yes</td></tr>
<tr><td>N</td><td>No</td></tr>
<tr><td>U</td><td>No information in the record</td></tr>
<tr><td>W</td><td>Clinically undetermined</td></tr>
<tr><td>1 or blank</td><td>Exempt from POA reporting</td></tr>
</table>
*Blank or 1 is only allowed for diagnoses excluded by CMS for the specific diagnosis code.</td></tr>
<tr><td>73</td><td>Reserved</td><td>Reserved for Assignment by the NUBC</td></tr>
<tr><td>74</td><td>Principal Procedure Code and Date Required if applicable</td><td>Principal Procedure Code and Date – Enter the ICD- procedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date.
Note: For inpatient claims, a procedure code or one of the diagnosis codes of Z5309 through Z538 must appear in this locator (or locator 67) when revenue codes 0360-0369 are used in locator 42 or the claim will be rejected.
Procedures that are done in the Emergency Room (ER) one day prior to the member being admitted for an inpatient hospitalization from the ER must be included on the inpatient claim.
DO NOT USE DECIMALS.</td></tr>
</table>

74a-e	**Other Procedure Codes and Date Required if applicable**	**Other Procedure Codes and Date –** Enter the ICD- procedure codes identifying all significant procedures other than the principal procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. **DO NOT USE DECIMALS.**
75	Reserved	Reserved for assignment by the NUBC
76	**Attending Provider Name and Identifiers Required**	**Attending Provider Name and Identifiers -** Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Inpatient: Enter the Attending NPI number. Outpatient: Enter the NPI number for the physician who performs the principal procedure.
77	**Operating Physician Name and Identifiers Required if applicable**	**Operating Physician Name and Identifiers -** Enter the name and the NPI number of the individual with the primary responsibility for performing the surgical procedure(s). This is required when there is a surgical procedure on the claim. Inpatient: Enter the NPI number assigned by Medicaid for the operating physician attending the patient. Outpatient: Enter the NPI number assigned by Medicaid for the operating physician who performs the principal procedure.
78-79	**Other Provider Name and Identifiers Required if applicable**	**Other Physician ID. -** Enter the NPI for the Primary Care Physician (PCP) who authorized the inpatient stay or outpatient visit. For Client Medical Management (CMM) patients referred to the emergency room by the PCP, enter the NPI number and attach the Practitioner Referral Form (DMAS-70). Non-emergency Emergency Room visits will be paid at a reduced rate. Enter the NPI PCP provider number for all inpatient stays. For Hospice Providers: If revenue code 0658 is billed, then enter the nursing facility provider NPI number in this locator.

80	**Remarks Field**	**Remarks Field –** Enter additional information necessary to adjudicate the claim. Enter a brief description of the reason for the submission of the adjustment or void. If there is a delay in filing, indicate the reason for the delay here and/or include an attachment. Provide other information necessary to adjudicate the claim.
81	**Code-Code Field Required if applicable**	**Code-Code Field –** Enter the provider taxonomy code for the billing provider when the adjudication of the claim is known to be impacted. DMAS will be using this field to capture taxonomy for claims that are submitted with one NPI for multiple business types or locations (eg, Rehabilitative or Psychiatric units within an acute care facility; Home Health Agency with multiple locations). **Code B3 is to be entered in first (small) space and the provider taxonomy code is to be entered in the (second) large space. The third space should be blank.**

Note: Hospitals with one NPI must use one of the taxonomy codes below when submitting claims for the different business types noted below:

Service Type Description	Taxonomy Code(s)
Hospital, General	282N00000X
Rehabilitation Unit of Hospital	223Y00000X
Psychiatric Unit of Hospital	273R00000X
Private Mental Hospital (inpatient)	283Q00000X
Rehabilitation Hospital	283X00000X
Psychiatric Residential Inpatient Facility	323P00000X- Psychiatric Residential Treatment Facility
Transportation-Emergency Air or Ground Ambulance	3416A0800X – Air Transport 3416L0300X – Land Emergency Transport
Clinical Medical Laboratory	291U00000X
Independent Physiological Lab	293D00000X

If you have a question related to Taxonomy, please e-mail DMAS at NPI@dmas.virginia.gov.

Mailing Address for Claims

Forward the original with any attachments for consideration of payment to:

Department of Medical Assistance Services

P.O. Box 27443

Richmond, Virginia 23261-7443

Providers are encouraged to maintain a copy of the claim in their provider files for future reference.

Billing Instructions: Special Note: Taxonomy (Rehab)

With the implementation of the National Provider Identifier (NPI), it will become necessary in some cases to include a taxonomy code on claims submitted to DMAS for all of our programs: Medicaid, FAMIS, and SLH. Prior to using the NPI, DMAS assigned a unique number to a provider for each of the service types performed, but with NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudicated and paid based on the service type, our system must determine which service type the provider intended to be assigned to a particular claim. If the NPI can represent more than one service type, a taxonomy code must be sent so the appropriate service type can be assigned.

Note: Hospitals with **one** NPI must use a taxonomy code on all claim submissions for the different business types.

Service Type Description	Taxonomy Code(s)
Rehabilitation Unit of Hospital	273Y00000X
Rehabilitation Hospital	283X00000X
Rehabilitation Agency	261QR0400X

If you have a question related to Taxonomy, please e-mail DMAS at NPI@dmas.virginia.gov.

Forward the original with any attachments for consideration of payment to: Department of Medical Assistance Services

P.O. Box 27443

Richmond, Virginia 23261-7443

Maintain the Institution copy in the provider files for future reference.

Billing Instructions: UB-04 (CMS-1450) Adjustment and Void Invoices

- To adjust a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges.
  - Type of Bill (Locator 4) – Enter code 0117 for inpatient hospital services or enter code 0137 for outpatient services.
  - Locator 64 – Document Control Number - Enter the sixteen digit claim internal control number (ICN) of the paid claim to be adjusted. The ICN appears on the remittance voucher.
  - Locator 68 – Enter the four digit adjustment reason code (refer to the below listing for codes acceptable by DMAS.
  - Remarks (Locator 80) – Enter an explanation for the adjustment.

NOTE: Inpatient claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and resubmitted as an original claim.

- Admission Date
- From or Through Date
- Discharge Status
- Diagnosis Code(s)
- Procedure Code(s)

Acceptable Adjustment Codes:

Code	Description
1023	Primary Carrier has made additional payment
1024	Primary Carrier has denied payment
1025	Accommodation charge correction
1026	Patient payment amount changed
1027	Correcting service periods
1028	Correcting procedure/ service code
1029	Correcting diagnosis code
1030	Correcting charge
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification number
1053	Adjustment reason is in the Misc. Category

- To **void** a previously paid claim, complete the following data elements on the UB-04 CMS-1450:
- Type of Bill (Locator 4) – Enter code 0118 for inpatient hospital services or enter code 0138 for outpatient hospital services.
- Locator 64 – Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be voided. The claim reference number appears on the remittance voucher.
- Locator 68 – Enter the four digit void reason code (refer to the below listing for codes acceptable by DMAS.
- Remarks (Locator 80) – Enter an explanation for the void.

Acceptable Void Codes:

Code	Description
1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Billing Instructions: Instructions For Use of the CMS-1500 (02-12), Billing Form

The Direct Data Entry (DDE) CMS-1500 claim form on the Virginia Medicaid Web Portal will be updated to accommodate the changes to locators 21 and 24E on 4/1/2014. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The

DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

To bill for services, the Health Insurance Claim Form, CMS-1500 (02-12), invoice form must be used for paper claims received on or after April 1, 2014. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12). The purpose of the CMS-1500 (02-12) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid members.

SPECIAL NOTES: The provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

Locator		**Instructions**
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Detention Order (EDO).**
1a	**REQUIRED**	**Insured's I.D. Number -** Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	**REQUIRED**	**Patient's Name -** Enter the name of the member receiving the service.
3	Not Required	Patient's Birth Date (DOB)
4	Not Required	Insured's Name
5	Not Required	Patient's Address
6	Not Required	Patient Relationship to Insured
7	Not Required	Insured's Address
8	Not Required	Reserved for NUCC Use
9	Not Required	Other Insured's Name
9a	Not Required	Other Insured's Policy or Group Number
9b	Not Required	Reserved for NUCC Use
9c	Not Required	Reserved for NUCC Use
9d	Not Required	Insurance Plan Name or Program Name
10	**REQUIRED**	Is Patient's Condition Related To: Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.

10d	Conditional	Claim Codes (Designated by NUCC) Enter "ATTACHMENT" if documents are attached to the claim forms.
11	Not Required	Insured's Policy Number or FECA Number
11a	Not Required	Insured's Date of Birth
11b	Not Required	Other Claim ID
11c	**REQUIRED If applicable**	**Insurance Plan or Program Name** Providers that are billing for non-Medicaid MCO copays only- please insert “HMO Copay”.
11d	**REQUIRED If applicable**	**Is There Another Health Benefit Plan?** Providers should only check yes, if there is other third party coverage.
12	Not Required	Patient's or Authorized Person's Signature
13	Not Required	Insured's or Authorized Person's Signature
14	**REQUIRED If applicable**	**Date of Current Illness, Injury, or Pregnancy** **Enter date MM DD YY format Enter Qualifier 431 – Onset of Current Symptoms or Illness**
15	Not Required	Other Date
16	Not Required	Dates Patient Unable to Work in Current Occupation
17	**REQUIRED If applicable**	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a	**REQUIRED If applicable**	I.D. Number of Referring Physician - The ‘1D’ qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier ‘ZZ’ may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	**REQUIRED If applicable**	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	Not Required	Hospitalization Dates Related to Current Services
19	**REQUIRED If applicable**	**Additional Claim Information** Enter the CLIA #.
20	Not Required	Outside Lab
21 A-L	**REQUIRED**	**Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line ‘A’ field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. **Note: ICD Ind. Not required at this time.** **9= ICD-9-CM** **0=ICD-10-CM**
22	**REQUIRED If applicable**	**Resubmission Code – Original Reference Number.** Required for adjustment and void. See the instructions for Adjustment and Void Invoices.

23	**REQUIRED If applicable**	**Service Authorization (SA) Number** – Enter the SA number for approved services that require a service authorization.

NOTE: The locators 24A thru 24J have been divided into open areas and a shaded line area. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. ENTER REQUIRED INFORMATION ONLY.

24A lines 1-6 open area	**REQUIRED**	**Dates of Service** - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01/01/14). DATES MUST BE WITHIN THE SAME MONTH

24A lines 1- 6 red shaded	**REQUIRED If applicable**	**DMAS requires the use of qualifier 'TPL'.** This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is $27.08; red shaded area would be filled as **TPL27.08**. No spaces between qualifier and dollars. No $ symbol but the decimal between dollars and cents is required. **DMAS requires the use of the qualifier 'N4'.** This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug-related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number. **NOTE: DMAS is requiring the use of the Unit of Measurement Qualifiers following the NDC number for claims received on and after May 26, 2014. The unit of measurement qualifier code is followed by the metric decimal quantity Unit of Measurement Qualifier Codes:** • F2 – International Units • GR – Gram • ML – Milliliter • UN – Unit Examples of NDC quantities for various dosage forms as follows: • Tablets/Capsules – bill per UN • Oral Liquids – bill per ML • Reconstituted (or liquids) injections – bill per ML • Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit) • Creams, ointments, topical powders – bill per GR • Inhalers – bill per GR **BILLING EXAMPLES:** TPL, NDC and UOM submitted: TPL3.50N412345678901ML1.0 NDC, UOM and TPL submitted: N412345678901ML1.0TPL3.50 NDC and UOM submitted only: N412345678901ML1.0 TPL submitted only: TPL3.50 Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples) All supplemental information is to be left justified. **SPECIAL NOTE:** DMAS will set the coordination of benefit code based on information supplied as followed: • If there is nothing indicated or 'NO' is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2. • If locator 11d is checked 'YES' and there is nothing in the locator 24a red shaded line; DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. An EOB/documentation must be attached to the claim to verify non payment. • If locator 11d is checked 'YES' and there is the qualifier 'TPL' with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of $15.50. This relates to the old coordination of benefit code 3.

24B open area	**REQUIRED**	**Place of Service -** Enter the 2-digit CMS code, which describes where the services were rendered.
24C open area	**REQUIRED If applicable**	**Emergency Indicator -** Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**
24D open area	**REQUIRED**	**Procedures, Services or Supplies – CPT/HCPCS –** Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. **Modifier -** Enter the appropriate CPT/HCPCS modifiers if applicable.
24E open area	**REQUIRED**	**Diagnosis Code -** Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.** Claims with values other than A-L in Locator 24-E or blank may be denied.
24F open area	**REQUIRED**	**Charges** - Enter your total usual and customary charges for the procedure/services.
24G open area	**REQUIRED**	**Days or Unit** - Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	**REQUIRED If applicable**	**EPSDT or Family Planning** - Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24 I open	**REQUIRED If applicable**	**NPI** – This is to identify that it is a NPI that is in locator 24J
24 I	**REQUIRED If applicable**	**ID QUALIFIER** –The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line.
24J open	**REQUIRED If applicable**	Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J redshaded	**REQUIRED If applicable**	**Rendering provider ID# -** The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line.
25	Not Required	Federal Tax I.D. Number
26	**REQUIRED**	Patient's Account Number – Up to FOURTEEN alphanumeric characters are acceptable.
27	Not Required	Accept Assignment
28	**REQUIRED**	Total Charge - Enter the total charges for the services in 24F lines 1-6

29	**REQUIRED If applicable**	**Amount Paid – For personal care and waiver services only** – enter the patient pay amount that is due from the patient. **NOTE**: The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	Not Required	Rsvd for NUCC Use
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials -** The provider or agent must sign and date the invoice in this block.
32	**REQUIRED if applicable**	**Service Facility Location Information –** Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. **NOTE:** For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	**REQUIRED if applicable**	**NPI # -** Enter the 10 digit NPI number of the service location.
32b red shaded	**REQUIRED if applicable**	**Other ID#:** - The qualifier '1D' is required for the API entered in this locator. The qualifier of 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 32a open line.
33	**REQUIRED**	**Billing Provider Info and PH # -** Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid**.** **NOTE: Do NOT** use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a	**REQUIRED**	**NPI –** Enter the 10 digit NPI number of the billing provider.
33b red shaded	**REQUIRED**	**Other Billing ID -** The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 33a open line. **NOTE: DO NOT** use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

Service Type Description	Taxonomy Code
Renal Unit	261QE0700X

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (02-12), as an Adjustment Invoice **The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.**		
Locator 22	**Medicaid Resubmission** Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.	
	1023	Primary Carrier has made additional payment
	1024	Primary Carrier has denied payment
	1025	Accommodation charge correction
	1026	Patient payment amount changed
	1027	Correcting service periods
	1028	Correcting procedure/service code
	1029	Correcting diagnosis code
	1030	Correcting charges
	1031	Correcting units/visits/studies/procedures
	1032	IC reconsideration of allowance, documented
	1033	Correcting admitting, referring, prescribing, provider identification number
	1053	Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 (02-12) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim)

NOTE: ICNs can only be adjusted through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services Attn: Fiscal & Procurement Division, Cashier 600 East Broad St. Suite 1300

Richmond, VA 23219

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (02-12), as a Void Invoice **The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.**		
Locator 22	**Medicaid Resubmission** Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.	
	1042	Original claim has multiple incorrect items
	1044	Wrong provider identification number
	1045	Wrong enrollee eligibility number
	1046	Primary carrier has paid DMAS maximum allowance
	1047	Duplicate payment was made
	1048	Primary carrier has paid full charge
	1051	Enrollee not my patient
	1052	Miscellaneous
	1060	Other insurance is available
	Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).	

NOTE: ICNs can only be voided through the Virginia MMIS up

to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services Attn: Fiscal & Procurement Division, Cashier 600 East Broad St. Suite 1300

Richmond, VA 23219

Group Practice Billing Functionality

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility- based organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS- 1500 (02-12), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov.

Billing Instructions: Instructions for Completing the Paper CMS-1500 (02-12) Form for Medicare and Medicare Advantage Plan Deductible, Coinsurance and Copay Payments for Professional Services (Effective 11/02/2014)

The Direct Data Entry (DDE) Crossover Part B claim form is on the Virginia Medicaid Web Portal. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

Purpose:	A method of billing Medicare's deductible, coinsurance and copay for professional services received by a Medicaid member in the Virginia Medicaid program on the CMS 1500 (02-12) paper claim form. The CMS1500 (02-12) claim form must be used to bill for services received by a Medicaid member in the Virginia Medicaid program. The following instructions have numbered items corresponding to fields on the CMS1500 (02-12)
NOTE:	Note changes in locator 11c and 24A lines 1-6 red shaded area. These changes are specific to Medicare Part B billing only.

Locator	Instructions	
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Custody Order (ECO).**
1a	**REQUIRED**	**Insured's I.D. Number** - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.

2	**REQUIRED**	**Patient's Name** - Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To:** - Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known.
10d	Conditional	**Claim Codes (Designated by NUCC)** Enter "ATTACHMENT" if documents are attached to the claim form. **Medicare/Medicare Advantage Plan EOB should be attached.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	**REQUIRED**	**Insurance Plan or Program Name** Enter the word '**CROSSOVER**' **IMPORTANT: DO NOT** enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word **'CROSSOVER'**
11d	**REQUIRED** **If Applicable**	**Is There Another Health Benefit Plan?** If Medicare/Medicare Advantage Plan and Medicaid only, check "NO". Only check "Yes", if there is additional insurance coverage **other than** Medicare/Medicare Advantage Plan and Medicaid.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 – Onset of Current Symptoms or Illness
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	NOT REQUIRED	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a shaded red	NOT REQUIRED	I.D. Number of Referring Physician - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	NOT REQUIRED	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Additional Claim Information Enter the CLIA #.
20	NOT REQUIRED	Outside Lab?
21 A-L	**REQUIRED**	**Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. **Note: ICD Ind. Not required at this time.**

<table>
<tr>
<td>22</td>
<td>REQUIRED
If Applicable</td>
<td>
Resubmission Code – Original Reference Number. Required for adjustment or void. Enter one of the following resubmission codes for an adjustment:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1023</td><td>Primary Carrier has made additional payment</td></tr>
<tr><td>1024</td><td>Primary Carrier has denied payment</td></tr>
<tr><td>1025</td><td>Accommodation charge correction</td></tr>
<tr><td>1026</td><td>Patient payment amount changed</td></tr>
<tr><td>1027</td><td>Correcting service periods</td></tr>
<tr><td>1028</td><td>Correcting procedure/ service code</td></tr>
<tr><td>1029</td><td>Correcting diagnosis code</td></tr>
<tr><td>1030</td><td>Correcting charge</td></tr>
<tr><td>1031</td><td>Correcting units/visits/studies/procedures</td></tr>
<tr><td>1032</td><td>IC reconsideration of allowance, documented</td></tr>
<tr><td>1033</td><td>Correcting admitting, referring, prescribing, provider identification number</td></tr>
<tr><td>1053</td><td>Adjustment reason is in the Misc. Category</td></tr>
</table>
Enter one of the following resubmission codes for a void:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1042</td><td>Original claim has multiple incorrect items</td></tr>
<tr><td>1044</td><td>Wrong provider identification number</td></tr>
<tr><td>1045</td><td>Wrong enrollee eligibility number</td></tr>
<tr><td>1046</td><td>Primary carrier has paid DMAS maximum allowance</td></tr>
<tr><td>1047</td><td>Duplicate payment was made</td></tr>
<tr><td>1048</td><td>Primary carrier has paid full charge</td></tr>
<tr><td>1051</td><td>Enrollee not my patient</td></tr>
<tr><td>1052</td><td>Miscellaneous</td></tr>
<tr><td>1060</td><td>Other insurance is available</td></tr>
</table>
Original Reference Number - Enter the claim reference number/ICN of the Virginia Medicaid paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted or voided. Only one paid claim can be adjusted or voided on each CMS-1500 (02-12) claim form. (Each line under Locator 24 is one claim).
NOTE: ICNs can only be adjusted or voided through the Virginia MMIS up to three years from the date the claim was paid. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted or voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:
• A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
• An explanation about the refund.
• A copy of the remittance page(s) as it relates to the refund check amount.
• Mail all information to:
Department of Medical Assistance Services
Attn: Fiscal & Procurement
Division Cashier
600 East Broad St, Suite 1300
Richmond, VA 23219
</td>
</tr>
<tr>
<td>23</td>
<td>REQUIRED
If Applicable</td>
<td>Prior Authorization (PA) Number – Enter the PA number for approved services that require a service authorization.
NOTE: The locators 24A thru 24J have been divided into open and shaded line areas. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. <u>ENTER REQUIRED INFORMATION ONLY.</u></td>
</tr>
<tr>
<td>24A lines 1-6 open area</td>
<td>REQUIRED</td>
<td>Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01 01 14).</td>
</tr>
</table>

24A-H lines 1- 6 red shaded	**REQUIRED If Applicable**	**NEW INFORMATION! DMAS is requiring the use of the following qualifiers in the red shaded for Part B billing:** **• A1 = Deductible (Example: A120.00) = $20.00 ded** **• A2 = Coinsurance (Example: A240.00) = $40.00 coins** **• A7= Copay (Example: A735.00) = $35.00 copay** **• AB= Allowed by Medicare/Medicare Advantage Plan (Example AB145.10) = $145.10 Allowed Amount** **• MA= Amount Paid by Medicare/Medicare Advantage Plan (Example MA27.08) see details below** **• CM= Other insurance payment (not Medicare/Medicare Advantage Plan) if applicable (Example CM27.08) see details below** **• N4 = National Drug Code (NDC)+Unit of Measurement** **'MA'**: This qualifier is to be used to show **Medicare/Medicare Advantage Plan's** payment. The 'MA' qualifier is to be followed by the dollar/cents amount of the payment by Medicare/Medicare Advantage Plan Example: Payment by Medicare/Medicare Advantage Plan is $27.08; enter **MA27.08** in the red shaded area '**CM**': This qualifier is to be used to show the amount paid by the insurance carrier **other than Medicare/Medicare Advantage plan**. The '**CM**' qualifier is to be followed by the dollar/cents amount of the payment by the other insurance. Example: Payment by the other insurance plan is $27.08; enter **CM27.08** in the red shaded area NOTE: No spaces are allowed between the qualifier and dollars. No $ symbol is allowed. The decimal between dollars and cents is required. **DMAS is requiring the use of the qualifier 'N4'**. This qualifier is to be used for the National Drug Code (NDC) whenever a drug related HCPCS code is submitted in 24D to DMAS. The Unit of Measurement Qualifiers must follow the NDC number. The unit of measurement qualifier code is followed by the metric decimal quantity or unit. Do not enter a space between the unit of measurement qualifier and NDC. Example: N400026064871UN1.0 **Any spaces unused for the quantity should be left blank.** **Unit of Measurement Qualifier Codes:** **• F2 – International Units** **• GR – Gram** **• ML – Milliliter** **• UN – Unit** **Examples of NDC quantities for various dosage forms as follows:** **a. Tablets/Capsules – bill per UN** **b. Oral Liquids – bill per ML** **c. Reconstituted (or liquids) injections – bill per ML** **d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)** **e. Creams, ointments, topical powders – bill per GR** **f. Inhalers – bill per GR** **Note: All supplemental information entered in locator 24A thru 24H is to be left justified.** **Examples:** 1. **Deductible is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $20.00, Medicare/Medicare Advantage Plan Paid Amt is $16.00, Coinsurance is $4.00.** - **Enter:A110.00 AB20.00 MA16.00 A24.00** 2. **Copay is $35.00, Medicare/Medicare Advantage Plan Paid Amt is $0.00 Medicare/Medicare Advantage Plan Allowed Amt is $100.00** - **Enter: A735.00 MA0.00 AB100.00** 3. **Medicare/Medicare Advantage Plan Paid Amt is $10.00, Other Insurance payment is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $10.00, Coinsurance is $5.00, NDC is 12345678911, Unit of measure is 2 grams** - **Enter: MA10.00 CM10.00 AB10.00 A25.00 N412345678911GR2** ****Allow a space in between each qualifier set****
24B open area	**REQUIRED**	**Place of Service** - Enter the 2-digit CMS code, which describes where the services were rendered.
24C open area	**REQUIRED If applicable**	**Emergency Indicator** - Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**
24D open area	**REQUIRED**	**Procedures, Services or Supplies – CPT/HCPCS –** Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. **Modifier** - Enter the appropriate CPT/HCPCS modifiers if applicable.
24E open area	**REQUIRED**	**Diagnosis Code -** Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.** Claims with values other than A-L in Locator 24-E or blank will be denied.
24F open area	**REQUIRED**	Charges - Enter the Medicare/Medicare Advantage Plan billed amount for the procedure/services. **NOTE: Enter the Medicare/Medicare Advantage Plan Copay amount as the charged amount when billing for the Medicare/Medicare Advantage Plan Copay ONLY.**
24G open area	**REQUIRED**	**Days or Unit -** Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	**REQUIRED If applicable**	**EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I open	**REQUIRED If applicable**	**NPI –** This is to identify that it is a NPI that is in locator 24J
24 I redshaded	**REQUIRED If applicable**	**ID QUALIFIER –**The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line.
24J open	**REQUIRED If applicable**	**Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J redshaded	**REQUIRED If applicable**	**Rendering provider ID# -** If the qualifier '1D' is entered in 24I shaded area enter the API in this locator. If the qualifier 'ZZ' was entered in 24I shaded area enter the provider taxonomy code if the NPI is entered in locator 24J open line.
25	NOT REQUIRED	Federal Tax I.D. Number
26	**REQUIRED**	**Patient's Account Number –** Up to FOURTEEN alphanumeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	**REQUIRED**	**Total Charge -** Enter the total charges for the services in 24F lines 1-6

29	**REQUIRED If applicable**	**Amount Paid –** For personal care and waiver services only – enter the patient pay amount that is due from the patient. **NOTE:** The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED	Rsvd for NUCC Use
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials -** The provider or agent must sign and date the invoice in this block.
32	**REQUIRED If applicable**	**Service Facility Location Information –** Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. **NOTE:** For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	**REQUIRED If applicable**	**NPI # -** Enter the 10 digit NPI number of the service location.
32b red shaded	**REQUIRED If applicable**	**Other ID#: -** The qualifier '1D' is required with the API entered in this locator. The qualifier of 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 32a open line.
33	**REQUIRED**	**Billing Provider Info and PH # -** Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	**REQUIRED**	**NPI –** Enter the 10 digit NPI number of the billing provider.
33b red shaded	**REQUIRED If applicable**	**Other Billing ID -** The qualifier '1D' is required with the API entered in this locator. The qualifier 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 33a open line. **NOTE: DO NOT** use commas, periods, space, hyphens or other punctuations between the qualifier and the number. The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files. Mail the completed claims to: Department of Medical Assistance Services CMS Crossover P. O. Box 27444 Richmond, Virginia 23261-7444

Invoice Processing (PP)

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a crossreference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
  - **Approved** - Payment is approved or pended.
  - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
  - **Pend** - Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

Please use this link to search for DMAS Forms:
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch

Exhibits: Revenue Code(s) (Rehab)

CODE: Four digits, right justified, no leading zeros.

0110	Room and Board, General Classification
0120	Room and Board, General Classification
0130	Room and Board, General Classification
0150	Room and Board, General Classification
0230	Incremental Nursing Care, General Classification
0250	Pharmacy, General Classification
0251	Pharmacy, Generic Drugs
0252	Pharmacy, Non-Generic Drugs
0253	Pharmacy, Take Home Drugs
0255	Pharmacy, Incident to Radiology
0257	Pharmacy, Non-Prescription Drugs
0258	Pharmacy, IV Solutions
0259	Pharmacy, Other Pharmacy
0260	Equipment for and Administration of IV's, General Classification
0261	Equipment for and Administration of IVs, Infusion Pump
0269	Equipment for and Administration of IVs, Other IV Therapy
0270	Medical/Surgical, General Classification
0272	Medical/Surgical, Sterile Supply
0273	Medical/Surgical, Take Home Supplies
0274	Medical/Surgical, Prosthetic Devices
0277	Medical/Surgical, Oxygen Take Home
0279	Medical/Surgical, Other Supplies/Devices
0290	Durable Medical, General Classification
0291	Durable Medical, Rental
0292	Durable Medical, Purchase New
0293	Durable Medical, Purchase Used
0299	Durable Medical, Other Equipment
0300	Laboratory, General Classification
0301	Laboratory, Chemistry
0302	Laboratory, Immunology
0305	Laboratory, Hematology
0306	Laboratory, Bacteriology and Microbiology
0307	Laboratory, Urology
0309	Laboratory, Other
0320	Radiology/Diagnostic, General Classification
0321	Radiology/Diagnostic, Angiocardiography
0322	Radiology/Diagnostic, Arthrography
0323	Radiology/Diagnostic, Arteriography

0324	Radiology/Diagnostic, Chest X-Ray
0329	Radiology/Diagnostic, Other

0350	CT Scan, General Classification
0351	CT Scan, Head Scan
0352	CT Scan, Body Scan
0359	CT Scan, Other
0360	Operating Room Services, General Classification
0361	Operating Room Services, Minor Surgery
0369	Operating Room Services, Other
0370	Anesthesia, General Classification
0371	Anesthesia, Incident to Radiology
0379	Anesthesia, Other
0400	Other Imaging Services, General Classification
0401	Other Imaging Services, Mammography
0402	Other Imaging Services, Ultrasound
0409	Other Imaging Services
0410	Respiratory Services, General Classification
0412	Respiratory Services, Inhalation Services
0413	Respiratory Services, Hyperbaric Oxygen Therapy
0419	Respiratory Services, Other

0420* Physical Therapy, General Classification 0422* Physical Therapy, Hourly Charge

0429* Physical Therapy, Other

0430* Occupational Therapy, General Classification 0432* Occupational Therapy, Hourly Charge

0439* Occupational Therapy, Other

0440* Speech-Language Pathology, General

Classifi-cation	
0442* Speech-Language Pathology, Hourly Charge 0449* Speech-Language Pathology, Other	
0471	Audiology, Diagnostic
0472	Audiology, Treatment
0479	Audiology, Other
0542	Ambulance, Medical Transport
0544	Ambulance, Oxygen
0610	Magnetic Resonance Imaging, General Classification
0611	Magnetic Resonance Imaging, Brain (including brain stem)
0612	Magnetic Resonance Imaging, Spinal Cord including spine)
0619	Magnetic Resonance Imaging, Other
0621	Medical/Surgical Supplies, Incident to Radiology
0700	Cast Room, General Classification
0730	EKG/ECG, General Classification
0731	EKG/ECG, Holter Monitor
0732	EKG/ECG, Telemetry
0739	EKG/ECG, Other
0740	EEG, General Classification
0749	EEG, Other
0760	Treatment or Observation Room, General Classification
0769	Treatment or Observation Room, Other Treatment
0790	Lithotripsy, General Classification
0799	Lithotripsy, Other
0911	Psychiatric/Psychological Services, Rehabilitation
0922	Other Diagnostic Services, Electromyelogram
0941	Other Therapeutic Services, Recreational Therapy

0943	Other Therapeutic Services, Cardiac Rehabilitation
0946	Other Therapeutic Services, Air Fluid Support Beds

0949** Other Therapeutic Services, Cognitive Therapy Only 0997 Patient Convenience Items, Admission Kits

0001 Total charge

* This code only applies to inpatient rehabilitation hospitals.

Quality Management Review and Control (Rehab)

Under federal regulations, the Medical Assistance Program must review and evaluate the care and services paid through Medicaid, including the provision of services by providers and the utilization of services by program participants/individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS), or its contractors, conducts periodic quality management reviews on all programs. DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Provider Participation Agreement with DMAS, the provider also agrees to provide access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or authorized representatives, and authorized federal personnel upon reasonable request.

This chapter provides detailed information on provider documentation requirements. This chapter also provides information on quality management reviews (QMRs), utilization control and audits conducted by DMAS or its contractors.

Financial Review and Verification

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is

subject to retraction. DMAS and the MCOs will perform the financial review and verification of services for their contracted providers to ensure that the provider bills for services consistent with the DMAS policy as well as with the provider's contract with the MCO.

Referrals To the Client Medical Management (CMM) Program

DMAS providers may refer individuals receiving Medicaid/FAMIS Plus or FAMIS benefits who are suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of DMAS. Referred individuals will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate individuals on the appropriate use of medical services, particularly emergency room services. Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Division

Department of Medical Assistance Services 600
East Broad Street, Suite 1300

Richmond, Virginia 23219

To contact by telephone, 1-804-786-6548, or the CMM HELPLINE AT 1-888-323-0589. When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his/her name and telephone number in case DMAS has questions regarding the referral.

U.R. Plans & QMR: Intensive Rehabilitation & CORF Services (Rehab)

Quality Management Review (QMR)

Quality management reviews are important to ensure high quality care and the appropriate provision of services. Many of the review requirements respond to federal

and/or state mandates. Rehabilitation providers must comply with all of the requirements in order to receive Medicaid reimbursement for the services provided. (*Virginia Administrative Code*, 12 VAC 30-60-120; *Code of Federal Regulations,* 42 CFR, Part 456 – Utilization Control, and Parts 482 and 485 – Conditions of Participation)

Admission Review

DMAS, or its contractors, requires quality management review of intensive rehabilitative services for all Medicaid admissions. The intensive rehabilitation provider must have an annual utilization review plan approved by the Office of Health Facilities Regulation, Virginia Department of Health, or the appropriate licensing agency in the state in which the institution is licensed. DMAS staff or its contractors will review the functions associated with approved hospital utilization review plans for compliance with the *Code of Federal Regulations (CFR)*, 42 CFR §§ 456.101 through 456.145 (Reference these 42 CFR regulations for additional federal requirements for UR plans, admission reviews, and medical care evaluation studies).

The facility's utilization review coordinator must approve the medical necessity, within one business day of admission and document in the utilization review plan and the individual's medical record.

Utilization Review (UR) Plan

Following admission, an initial stay review date must be assigned within the 50th percentile of norms approved by the Utilization Review Committee except in circumstances properly documented in the progress notes and reflected on the utilization review sheets. Continued or extended stay review must be assigned prior to or on the date assigned for the initial stay. If the facility's Utilization Review Committee believes that an intensive continued stay is not medically necessary, it may review the case at any time.

If the admission or continued stay is found to be medically unnecessary, the attending physician must be notified and permitted to present additional information. If the hospital physician advisor continues to find the admission or continued stay unnecessary, a notice of adverse decision must be made within one business day after the admission or continued stay is denied. Copies of this decision must be sent by the designated agent to the hospital administrator, attending physician, individual and/or the individual's authorized representative

Medical Care Evaluation Studies (MCEs)

As part of their utilization review plan, hospitals must have one medical care evaluation study in process and one completed study each calendar year.

Utilization Review Plan (CORFs)

The Comprehensive Outpatient Rehabilitation Facilities (CORF) must have in effect a written utilization review plan implemented at least quarterly to assess the necessity of services and to promote the most efficient use of services provided by the facility. The Utilization Review Committee, consisting of physicians and professionals representing each of the services provided by the facility, a committee of this group, or a group of similar composition comprised of professional personnel not associated with the facility, must carry out the utilization review plan. Refer to 42 CFR § 485.66 for additional requirements.

The utilization review plan must contain written procedures for evaluating the following:

- Admissions, continued care, and discharges using, at a minimum, the criteria established in the individual care policies of the facility;
- The applicability of the plan of care/treatment plan to established goals; and
- The adequacy of clinical records to assess the quality of services provided, to determine whether the facility's policies and clinical practices are compatible, and to promote the appropriate and efficient utilization of services.

Rehabilitation providers must provide the same rehabilitation services to the Medicaid individual as provided to the general population, in accordance with the established Medicaid reimbursement rate. A Medicaid-enrolled provider must accept Medicaid payment as payment in full.

Services not specifically documented in the individual’s medical record as having been rendered will be deemed not rendered, and reimbursement will not be provided. All rehabilitative services shall be provided in accordance with guidelines found in the *Virginia Administrative Code* and the *Virginia Medicaid Rehabilitation Manual*.

Documentation Requirements: Intensive Rehabilitation and CORF Services

Physician Certifications, Recertifications and Renewal of the Plan of Care Orders

- A physician is required to complete the admission certification (DMAS-127) of intensive rehabilitation services and the initial plan of care orders.

- A 60-day recertification (DMAS-128) must be performed by a physician, or a licensed practitioner of the healing arts, such as a nurse practitioner or a physician assistant, within the scope of his/her practice under State law.
- If therapy services are recertified by a practitioner of the healing arts other than

a physician, supervisory requirements must be performed by a physician as required by the Virginia Department of Health Professions regulations. [Virginia State Code § 54.1-2857.02; 42 Code of Federal Regulations, 456.60 (a)(1)(b)(1), 456.80 (a)].

- For CORF providers, the provider requirements do not permit nurse practitioners or physician assistants to order CORF intensive rehabilitation services. A physician is responsible for all documentation requirements, including, but not limited to, admission certifications, recertifications, plan of care orders, progress notes, etc., as defined in this chapter. [42 Code of Federal Regulations, 485.58 (a)(1)].
- Providers must refer to Chapter IV of this manual for additional clarification on program and documentation requirements.

Physician Documentation Requirements (or other licensed practitioners)

Physician Admission Rehabilitation Evaluation:

The physician admission rehabilitation evaluation must include, but is not limited to, the following:

- The prognosis, clinical signs and symptoms necessitating admission;
- A description of prior treatment and, if applicable, attempts to rehabilitate the individual in a less intensive setting;
- History and Physical Exam;
- The written initial certification statement (DMAS-127) of the need for intensive rehabilitation; and
- The identification of a discharge plan/disposition.

Physician Plan of Care/Treatment Plan:

The physician plan of care/treatment plan must be written specific to the individual and must include orders for medications, rehabilitative therapies (including the frequency and duration of services), treatments, diet, and other services as needed such as psychology, social work, therapeutic recreation, etc. The plan must be reviewed and updated at least every 60 days on the DMAS-126.

Physician Admission and Discharge Orders:

The physician is responsible for admission and discharge orders (if verbal orders are given, written orders must be signed and dated within three calendar days). A physician order is required to discontinue any therapy treatment prior to an individual's discharge.

Physician Progress Notes:

The physician progress notes must be written at least monthly (every 30 days) and must include, but is not limited to:

- Changes in the individual's condition;
- Individual response to treatment;
- Renewal of recertification statement of the continuing need for intensive rehabilitation written at least every 60 days on the DMAS-128; and
- Discharge disposition statement.

Required DMAS Forms for Physician Use – DMAS 126, 127 and 128

DMAS has three (3) forms that are required for physician use (implemented on May 1, 2002), for each Medicaid admission or if an individual is anticipated to be Medicaid eligible, these forms must be fully completed, signed and dated by the physician. The Code of Federal Regulations (CFR) require physician certification and recertification for intensive/inpatient or CORF rehabilitation per 42 CFR 456.60.

The three required DMAS forms are:

- DMAS Intensive Rehabilitation Physician Plan of Care Review (DMAS-126),
- DMAS Intensive Rehabilitation Admission Certification (DMAS-127), and
- DMAS Intensive Rehabilitation 60-Day Recertification (DMAS-128).

NOTE: Refer to the DMAS Medicaid Web Portal, Provider Forms Search link located at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal for access to these three required forms.

DMAS-126: For those intensive/inpatient or CORF rehabilitation stays that continue for 60 days or more, the physician must complete the DMAS-126 form. Review of the 60-day plan of care (DMAS-126) renewal is defined as reviewing all physician orders pertaining to medications, rehabilitative therapies, treatments, diet, and other services as needed such as psychology, social work, therapeutic recreation, etc. The plan of care review of the physician orders provides the physician with an opportunity to review the individual's status over the past two months, rather than a day-to-day review. The physician must determine in writing on the DMAS-126 form, what services need to be continued, added, changed, or deleted, based on the individual's needs. The required form (DMAS-126) must be fully completed, signed and dated by the physician, and placed in the physician order section of the medical record.

DMAS-127: For all new intensive/inpatient or CORF admissions of a Medicaid individual or for those anticipated to be Medicaid eligible, the physician must complete the DMAS-

127 form for admission certification, which is a federal regulatory requirement. The physician is acknowledging that the individual does meet the intensive inpatient rehabilitation criteria for admission and the physician is certifying that the individual meets the certification requirements. The required form (DMAS-127) for this purpose must be fully completed, signed and dated by the physician, and placed in the physician order section of the medical record.

DMAS-128: For those intensive/inpatient or CORF rehabilitation stays that continue for

60 days or more, the physician must complete the DMAS-128 form for the 60-day recertification, which is a federal regulatory requirement. The physician is acknowledging that the individual continues to meet the intensive inpatient or CORF rehabilitation criteria for continued stay and the physician is certifying that the individual meets the recertification requirements. The required form (DMAS-128) for this purpose must be fully completed, signed and dated by the physician, and placed in the physician order section of the medical record.

NOTE: For an individual who has applied for and is pending Virginia Medicaid eligibility and it is even remotely anticipated that the person may become Medicaid eligible (either during or after an inpatient rehabilitation stay), it is *strongly recommended* that the DMAS- 127 admission certification form be completed upon admission, so the provider avoids the possible risk of not receiving Medicaid reimbursement, if needed. If the person remains 60 days or more, it is *strongly recommended* that the DMAS-126 and DMAS-128 forms be completed. If Medicaid is approved retroactively, and the provider billed Medicaid for any portion of the stay, if any of these forms were not completed upon admission or at the 60 day interval, this will be an audit and possible retraction issue for the entire stay if these required forms were not completed.

Physician Signature Requirements

All physician documentation must be signed and fully dated (month/day/year) by the physician. A required physician signature for DMAS purposes may include signatures, written initials, computer/electronic entry, or rubber stamp initialed by the physician at the time used. These methods only apply to DMAS requirements. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide facility administration with a signed

statement to the effect that he/she is the only person who will use the rubber stamp.

The use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the providers own internal policies. Refer to the *Electronic Signatures* section located in this chapter for more detailed information.

Rehabilitation Nursing

A registered nurse (RN), or a licensed practical nurse (LPN) under the supervision of a registered nurse (RN), is responsible for and must complete, sign, title and fully date, all of the following:

- An admission evaluation and a written plan of care/treatment plan with measurable individual goals completed within 24 hours of admission;
- A review of the individual plan of care/treatment plan, as needed, but at least every two weeks; and
- A weekly nursing summary, which reflects the care provided, individual/family education, changes in the individual's condition, the individual's response to treatment; and revision of the individual goals as needed; and
- Medications and treatments administered and charted as ordered by the physician.
- A review of medications, at least monthly, to include identification of medications that may be discontinued or altered, and validation of the proper administration of ordered medications.

The individual's condition must require, in addition to any acute rehabilitation nursing services, the nursing knowledge and skills necessary to identify nursing needs and treat individuals whose conditions are characterized by altered cognitive and functional ability. The need for these rehabilitative nursing services is determined by deficits documented in the rehabilitative nursing admission assessment. This assessment and a physician- approved plan of care/treatment plan are developed by a registered nurse (or LPN under the supervision of the RN) experienced in rehabilitation.

The registered nurse (or LPN under the supervision of the RN) develops the plan of care/treatment plan by documenting individualized, measurable, goals with time frames for goal achievement and the nursing interventions necessary to assist the individual in achieving the goals. The nursing plan of care/treatment plan must reflect

the expectation of significant improvement in the identified deficits. When using computerized and/or standardized plans of care, documentation must incorporate all of the above described plan of care components and be specific to the individual's needs.

A program participant/individual's response to nursing interventions and any resultant changes in the individual's goals must be documented in the weekly nursing summary by nurses responsible for the individual's care. The registered nurse must review the individual's response to the nursing plan of care/treatment plan at least every two weeks and document any necessary modifications to the plan of care/treatment plan.

Upon the individual's discharge from services, the RN (or LPN under the supervision of the RN) must complete a comprehensive discharge summary, to include the following components: functional outcome of the long-term goals, recommendations for follow-up care, and discharge disposition. The discharge summary must be completed within 30 days of the individual's discharge. The provider's discharge instruction form for the individual does not meet the DMAS documentation requirements for a discharge summary.

Rehabilitative Therapies (PT, OT, SLP, Cognitive, Therapeutic Recreation)

All rehabilitation services must be ordered by a physician or other licensed practitioner prior to the provision of services.

Admission Evaluation: Each therapist's admission evaluation must be completed by a registered or licensed therapist within seven (7) calendar days of admission and must include, but is not limited to:

- Medical Diagnosis of the individual;
- Clinical signs and symptoms;
- Medical history;
- Summary/History of any previous rehabilitation services;
- Prior/current functional status; and
- Therapist's recommendation for treatment.

Plan of Care/Treatment Plan: A plan of care/treatment plan within seven (7) calendar days of admission, specifically designed for the individual must be established and must include, but is not limited to:

- Individual measurable long-term and short-term goals;
- Time frames of achievement for all goals;

- Interventions (modalities/treatments/procedures);
- Frequency and duration of the therapies; and
- Discharge disposition/plan.

Progress Notes: Progress notes must be written at least every two weeks and must include, but are not limited to:

- Individual's response to treatment; and
- Review of the plan of care/treatment plan/goals.

Discharge from Services: Upon the individual's discharge from services, the licensed therapist must complete a comprehensive discharge summary, to include all of the following components:

- Functional outcome of the long-term goals,
- Recommendations for follow-up care,
- Discharge disposition,
- Completed within 30 days of the individual's discharge, and
- Signed, titled and fully dated by the licensed therapist.

Therapist Supervision of a Therapy Assistant (Applicable to PT, OT, and SLP)

Direct supervision by a qualified therapist includes initial direction and periodic observation of the individual's actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the licensed therapist (not the therapy assistant). When services are provided by a licensed or certified therapy assistant (i.e.: PTA, COTA, CFY/SLP or Speech-Language Assistant), the licensed therapist (i.e.: PT, OT, or SLP) must conduct an on-site supervisory visit at least every 30 days while therapy is being conducted, observe, and document accordingly.

If the supervisory therapist co-signs the assistant's progress visit notes, this action alone does not constitute a 30-day supervisory visit note. The supervisory therapist shall review the progress notes of the therapy assistant. The supervisory therapist documentation of the 30-day note shall include a review of the plan of care with the assistant and comments on any adjustments or revisions to the individual's therapy goals, as needed. If no adjustments or revisions are needed, the therapist should document accordingly. The supervisory 30- day review note must be signed, titled and fully dated by the therapist. Lack of documentation of the 30-day supervisory visit notes will result in a DMAS audit retraction of provider reimbursement.

Psychologist and Social Worker

All psychology and social work services must be ordered by a physician prior to the provision of services.

Admission Evaluation: An admission evaluation for psychology services must be written by a licensed psychologist or a licensed clinical social worker. For social work services an admission evaluation must be written by a qualified social worker within seven (7) calendar days of admission and must include:

- Psycho-Social History;
- Diagnosis; and
- Identified needs/problems.

Plan of Care/Treatment Plan: A plan of care/treatment plan within seven (7) calendar days of admission specifically designed for the individual must be established, reviewed/revised every two weeks and must include:

- Individual measurable long-term and short-term goals;
- Time frames for all goals;
- Interventions/approaches used;
- Frequency and duration of services offered; and
- Discharge disposition/plan*.

*Discharge planning is an integral part of the individual's plan of care/treatment plan developed by the team and coordinated by the social worker. The discharge plan must be addressed during the admission evaluation and must be reviewed/revised relative to the individual's and family's response to the rehabilitation program.

Progress Notes: Progress notes must be written at least every two weeks and must include, but are not limited to:

- Individual's response to treatment; and
- Review of the plan of care/treatment plan.

Discharge Summary: Upon the individual's discharge from services, the psychologist and social worker must complete a comprehensive discharge summary that includes the all of the following components:

- Functional outcome of the long-term goals,
- Recommendations for follow-up care,
- Discharge disposition,
- Discharge summary must be completed within 30 days of the individual's discharge, and

- Must be signed, titled and dated by the licensed staff.

Interdisciplinary Team

The interdisciplinary (ID) team must prepare written documentation of the ID plan of care/treatment plan within seven (7) calendar days of admission.

Documentation must include, but is not limited to:

- Needs of the individual;
- Individualized, measurable long and short-term goals;
- Approaches/interventions to be used to meet the goals;
- The discipline(s) responsible for the interdisciplinary goals;
- Evidence of goal revision and progress;

→ Time frames for all goals; and

→ Team plan reviewed/revised at least every two (2) weeks

Included in the interdisciplinary plan of care/treatment plan must be a discharge plan. This plan must facilitate an appropriate discharge and must include, but is not limited to:

- Individual's discharge destination;
- Any modifications and alterations necessary at the individual's home for discharge; and
- Alternative discharge plans if the initial plan is not feasible.

The effectiveness of an intensive rehabilitation program depends on the continuing coordination of all the professional disciplines involved in the individual's rehabilitation. Team conferences held at least every two weeks are required in order to review the plan of care/treatment plan, assess and document the individual's progress as well as any problems impeding progress. The team will consider possible resolutions to the identified problems, reassess the continuing validity of the rehabilitation goals established at the time of the initial evaluation, reassess the need for any adjustment in these goals or in the prescribed treatment program, and re-evaluate discharge plans.

Team documentation must demonstrate a coordinated team approach. A review by the

various team individuals of each other's progress notes does not constitute a team conference. A team conference must be held at least every two weeks to include a review of the plan of care and a summary of the team conference, noting the team members/disciplines (by full name and title) attendance and participation, as documented in the clinical record. Documentation must include approaches and progress made toward meeting established interdisciplinary goals, revisions/changes to goals, and revisions to the discharge plan.

General Documentation Requirements for Intensive Rehabilitation and CORF

For each individual, there must be a written plan of care/treatment plan established and reviewed and signed by a physician every 60 days. Services not specifically documented in the individual's record as having been rendered will be deemed not to have been rendered, and any inappropriate payment may be recovered by DMAS or its contractors. Each entry in the medical record must be signed, titled and dated (month/day/year) by the provider of treatment.

The medical record must include all of the following, but is not limited to:

- Diagnosis, current medical findings, including functional status, and the clinical signs and symptoms of the individual's condition, including the diagnosis justifying admission, and documentation of the extent to which the individual is aware of the diagnosis and prognosis;
- An accurate and complete chronological picture of the individual's clinical course and treatments, including any prior rehabilitation treatment. If appropriate, the summary of treatment furnished and the results achieved during previous periods of rehabilitation services or institutionalization must be provided;
- Plans of care/treatment plans by the interdisciplinary team and each involved discipline, specifically designed for the individual to include realistic, measurable, individualized goals with time frames for goal achievement;
- Physician orders and plan of care/treatment plan prior to the provision of services;
- Documentation of all treatment rendered to the individual with specific attention to the frequency, duration, interventions, response, and progress toward established goals. All entries must be fully signed and fully dated by the provider of the treatment (include the full name and title);
- Documentation of supervision of therapy assistants completed by a licensed

therapist every 30 days as described in this chapter;

- Documentation of changes in the individual's condition and changes in the plans of care/treatment plans (team and/or individual discipline);
- Documentation of team conferences, including the names of all attending;
- Discharge plans (see below); and
- Discharge summaries describing functional outcome, follow-up plans, and discharge disposition. The discharge summaries must be completed within 30 days of the individual's discharge.
- NOTE: If a therapy or service is discontinued prior to the individual's discharge from the intensive or CORF rehabilitation program, the therapist or other discipline must obtain a physician discharge order.

Discharge Planning for Intensive Rehabilitation and CORF

Discharge planning must be an integral part of the overall plan of care/treatment plan developed at the time of admission to the program.

- The plan shall identify the anticipated improvements in functional abilities and the probable discharge destination.
- The individual or the responsible party shall participate in the discharge planning.
- The discharge plan must demonstrate that adequate arrangements/services are made to meet the individual's needs in the new environment.
- Documentation concerning changes in the discharge plan as determined by the response to treatment, shall be entered into the record at least every two weeks as a part of the team conference, but more often if the individual's situation warrants.

Documentation Requirements: Outpatient Rehabilitation Services

Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services

The individual's medical record must contain sufficient documentation to clearly identify the individual and justify the need for services. Each discipline, physical therapy, occupational therapy, and speech-language pathology services must adhere to the documentation requirements.

Providers of Service

A physician or other licensed practitioner of the healing arts, such as a nurse practitioner or a physician assistant, within the scope of his/her practice under State law, may order services, develop the plan of care, and complete physician initial certification and recertifications under the direct supervision of a physician. If therapy services are ordered by a practitioner of the healing arts other than a physician, supervisory requirements must be performed by a physician as required by the Virginia Department of Health Professions regulations. (Virginia State Code § 54.1-2857.02; 42 Code of Federal Regulations, 440.130 (d), 485.711)

Early Intervention Services and School Therapy Services

Providers who offer PART C - Early Intervention Services (EIS) treatment for children under the age of 3, should refer to covered services and documentation requirements in the Early Intervention Services Manual on the DMAS Medicaid Web Portal located at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. For outpatient rehabilitation providers who provide rehabilitation therapy to Medicaid special education children within the school setting, providers should also refer to the DMAS Medicaid Web Portal for the LEA (Local Education Agency) Manual for information.

The required outpatient rehabilitation documentation in the individual's medical record must include **all** of the following, but is not limited to:

Physician Documentation (or other licensed practitioner)

A physician's order is required prior to the initiation of the evaluation/assessment. Physician orders must include all of the following, but is not limited to:

- A physician order/script prior to the initiation of the evaluation/assessment that identifies the specific therapy(s);
- A physician order/plan of care for treatment that identifies the therapy, measurable, individualized goals with time frames for goal achievement, modalities interventions, frequency, and duration;
- A physician order for discharge from services is required; and
- Each physician's entry into the record must be legibly signed, titled, and fully dated by the physician making the entry.

The physician is responsible for admission and discharge orders (if verbal orders are given, written orders must be signed and dated within three calendar days).

Therapist Documentation

Therapist assessment/evaluation must include all of the following, but is not limited to:

- Medical diagnosis;
- Clinical signs and symptoms;
- Medical history;
- Current functional status (strengths and deficits);
- Justification of therapeutic interventions;
- Summary of previous rehabilitative treatment and results;
- Extent to which the individual/responsible party is aware of the diagnosis and prognosis; and
- Therapist recommendation for treatment, signature/title/date.

When physician ordered, an evaluation or re-evaluation must be completed by a therapist when an individual is admitted to a service, when there is significant change in an individual's condition, or when an individual is readmitted to a service. There is no required time frame for completion of the therapy assessment once a physician order is received; however, it is recommended that the therapist conduct an evaluation/assessment in a timely manner to benefit the individual being assessed and to carry out the physician order.

Plan of Care/Treatment Plan

The plan of care/treatment plan must be specifically designed for the individual by the physician after consultation with the therapist(s). The initial plan of care/treatment plan may be prepared and signed by the therapist and then sent to the physician for signature. The plan of care/treatment plan must be reviewed/renewed by the therapist and the physician with modifications determined by the individual's response to therapy every 60 days or annually depending on the individual sub-group classification (for more information, refer to Chapter IV of this manual).

Any initial plan of care/treatment plan or periodic renewal written by the qualified therapist must be signed and dated by the physician within 21 days of implementation of the plan. If a physician signature is not obtained within 21 days of the implementation of the plan of care, reimbursement will not be made for that plan of care until the date of the physician signature. Reimbursement will not be made if, at the time of the physician signature, the plan of care valid time frame has expired. Services provided without a physician's dated signature or incomplete physician's order will not be reimbursed.

The plan of care/treatment plan must include all of the following, but is not limited to:

- Medical diagnosis;
- Current functional status (strengths and deficits);
- Individualized, measurable goals (long-term and short-term) which describe the anticipated level of functional improvement;
- Achievement time frames for all goals;
- Therapeutic interventions/treatments to be utilized by the therapist;
- Frequency and duration of the therapies; and
- Identification of a discharge plan and anticipated discharge date.

Discharge Planning

The discharge plan is developed upon admission as an integral part of the initial plan of care/treatment plan and must include all of the following, but is not limited to:

- The individual's anticipated functional status at discharge;
- The individual's anticipated discharge disposition and date;
- The individual's or responsible party's participation in discharge planning; and
- The changes in the plan as determined by the individual's response to therapy.

Verification of Services/Progress Notes

Progress notes must be accurate and provide a complete chronological picture of the individual's treatments and clinical course. Each therapy visit must be documented in the medical record. Failure to properly document the extent of services rendered in detail can result in an audit retraction of reimbursement.

Documentation must include all of the following, but is not limited to:

- Dated documentation for each individual treatment session (visit);
- Modality/treatment/activity utilized;
- Individual response to therapy relative to established goals;
- Changes in functional status;
- Changes in individual condition;
- Recommendations for continued treatment relative to established goals;
- Recommendations for continued treatment relative to modifications to the plan of care/treatment plan; and
- Identification of the therapist providing the treatment, including the full name and title, and signature date.

Progress note documentation by therapy assistants must meet the supervisory requirements as outlined in Chapter IV of this manual. Supervisory documentation must be evident every 30 days in the progress note section of the medical record.

Discharge Summary

The discharge summary must be completed within 30 days of discharge and must include all of the following, but is not limited to:

- The reason for discharge;
- The individual's functional status at discharge compared to admission status;
- The individual's status relative to established long-term goals met or not met;
- The recommendations for any follow-up care;
- The individual's discharge destination; and
- The qualified therapist, who developed the plan of care/treatment plan, must fully sign, title, and date the discharge summary.

NOTE: A physician discharge order is required to discontinue therapy services. The therapist discharge summary may be used to fulfill the physician discharge order requirements as long as the physician signs the summary within 30 days of discontinuation of services.

Therapist Supervision of a Therapy Assistant (Applicable to PT, OT, and SLP)

Direct on-site supervision by a qualified therapist includes initial direction and periodic observation of the individual's actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the licensed therapist (not the therapy assistant). When services are provided by a licensed or certified therapy assistant (i.e.: PTA, COTA, CFY/SLP or Speech-Language Assistant), the licensed therapist (i.e.: PT, OT, or SLP) must conduct an on-site supervisory visit at least every 30 days while therapy is being conducted, observe, and document accordingly.

If the supervisory therapist co-signs the assistant's progress visit notes, this action alone does not constitute a 30-day supervisory visit note. The supervisory therapist shall review the progress notes of the therapy assistant. The supervisory therapist documentation of the 30-day note shall include a review of the plan of care with the assistant and comments on any adjustments or revisions to the individual's therapy goals, as needed. If no adjustments or revisions are needed, the therapist should document accordingly. The supervisory 30- day review note must be signed, titled and fully dated by the therapist. Lack of documentation of the 30-day supervisory visit notes will result in a DMAS audit retraction of provider reimbursement.

General Documentation Requirements for Outpatient Rehabilitation

DMAS criteria for reimbursement of general outpatient rehabilitation are found throughout the provider manual and include all of the following, but are not limited to:

- A physician initial order, signed and dated by the physician prior to the provision of therapies;
- Evidence of the therapist admission assessment/evaluation;
- Provider "program-mandated" evaluations or re-evaluations will not be reimbursed;
- A plan of care/treatment plan prior to the provision of therapies;
- The plan of care/treatment plan signed and dated by the physician within 21 days of the implementation of the plan of care/treatment plan;
- Review and renewal of the physician order and plan of care/treatment plan every 60 days for acute conditions requiring services for less than 12 months;
- Review and renewal of the physician order and plan of care/treatment plan annually for non-acute, long-term conditions requiring services for greater than 12 months; the therapist plan of care/treatment plan with goals reviewed based on acute or non-acute conditions;
- Documentation of significant progress toward the individual goals within a reasonable period of time;
- Discipline progress notes for each therapy visit;
- Documentation of the appropriate and timely discharge planning; and
- Documentation of the discharge summary, upon the individual's discharge

Appendix D: Service Authorization Information (Rehab)

Service authorization (Srv Auth) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require Srv Auth and some may begin prior to requesting authorization.

Purpose of Service Authorization

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid/FAMIS eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity. Medallion 3 MCO-enrolled members are subject to service authorization requirements of the individual's MCO.

General Information Regarding Service Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for Srv Auth requests.

The Srv Auth entity will approve, pend, reject, or deny all completed Srv Auth requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care (MCO) program, the Srv Auth entity will honor the Medicaid MCO service authorization if the client has been retroactively disenrolled from the MCO. Similarly, the MCO will honor the Srv Auth Contractor's authorization based upon proof of authorization from the provider, DMAS, or the Srv Auth Contractor that services were authorized while the member was eligible under fee- for-service (not MCO enrolled) for dates where the member has subsequently become enrolled with a DMAS contracted MCO Srv Auth decisions by the DMAS Srv Auth Contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested. The Srv Auth Contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify member eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled members, the provider must follow the MCO's Srv Auth policy and billing guidelines.

Commonwealth Coordinated Care Plus (CCC Plus) Program

Members Transitioning into CCC Plus

For members that transition into the CCC Plus Program, the CCC Plus Health Plan will honor the Srv Auth contractor's authorization for a period of not less than 90 days or until the Srv Auth ends whichever is sooner, for providers that are in-and out-of-network.

When a member enrolls in CCC Plus, the provider should contact the CCC Plus Health Plan to obtain an authorization and information regarding billing for services if they have not been contacted the CCC Plus Health Plan.

Members Transitioning from CCC Plus and Back to Medicaid Fee-For Service (FFS)

Should a member transition from CCC Plus to Medicaid FFS, the provider must submit a request to the Srv Auth Contractor and needs to advise the Srv Auth Contractor that the request is for a CCC Plus transfer within 60 calendar days. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. The Srv Auth Contractor will honor the CCC Plus approval up to the last approved date but no more than 60 calendar days from the date of CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the SA Contractor will apply medical necessity/service criteria.

Should the request be submitted to the Srv Auth Contractor after the continuity of care period:

A. The dates of service within the continuity of care period will be honored for the 60-day timeframe;
B. The dates of service beyond the continuity of care period, timeliness will be waived and reviewed for medical necessity, all applicable criteria will be applied on the first day after the end of the continuity of care period
C. For CCC Plus Waiver Services, cap hours will be approved the day after the end of the continuity of care period up to the date of request. The continuation of service units will be dependent upon service criteria being met and will either be authorized or reduced accordingly as of the date of the request.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the *beginning* of the month. This will provide information for members who may be in transition from CCC Plus at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the SA Contractor's service authorization but the member's CCC Plus eligibility has been retro-voided, continuity of care days will not be approved by the CCC Plus health plan and will not be on the transition reports since the member never went into CCC Plus. The SA Contractor will re-open the original service authorization for the same provider upon provider notification.

CCC Plus Exceptions:

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Srv Auth Contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria but

timeliness will be waived as outlined above.)

- If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Srv Auth Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, click on the link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.

Service Authorization for Intensive and Outpatient Rehabilitation Services

Submitting Requests for Service Authorization

The contracted entity that provides service authorization services to DMAS is Keystone Peer Review Organization (KEPRO). Contact information for KEPRO is as follows:

KEPRO

2810 N. Parham Road, Suite 305

Henrico, VA 23294

Phone:

(804) 622-8900 (Richmond)

1-888-827-2884 (Toll Free)

1-888-VAPAUTH

Fax: 1-877-652-9329

1-877-OKBYFAX

Service Authorization reviews will be performed by DMAS' service authorization contractor, Keystone Peer Review Organization, (KEPRO). All submission methods

and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests submitted to KEPRO.

All requests for services must be submitted prior to services being rendered. There will be no retroactive authorization**.** This means that if the provider is untimely submitting the request, KEPRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied, and appeal rights provided.

Change in the Submission of Service Authorization Requests to KEPRO

KEPRO will accept requests through direct data entry (DDE), by fax, telephone or US mail. The preferred method is by DDE through KEPRO's provider portal, Atrezzo Connect. To access Atrezzo Connect on KEPRO's website, go to http://dmas.kepro.com. For direct data entry requests, providers must use Atrezzo Connect Provider Portal.

How to Register for Attrezzo Connect

The registration process for providers occurs immediately on-line. From http://dmas.kepro.com, providers not already registered with Atrezzo Connect may click on "*First Time Registration*" to be prompted through the registration process. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount.

The Atrezzo Connect User Guide is available at http://dmas.kepro.com. Click on the

Training tab, then the *General* tab.

Providers with questions about KEPRO's Atrezzo Connect Provider Portal may contact KEPRO by email at : atrezzoissues@kepro.com.

For service authorization questions, providers may contact KEPRO at: providerissues@kepro.com. KEPRO can also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

Faxing Requests to KEPRO

Providers must use the specific fax form required by KEPRO when requesting services. If the fax form is not accompanied by the request, KEPRO will reject the

request back to the provider and the provider must resubmit the entire request with the fax form. The DMAS 363 *(Outpatient Services Authorization Request Form)* is the appropriate fax form to use. Providers may fax requests to 1-877-652-9329. Forms are available on KEPRO's website at: http://dmas.kepro.com. Providers may click on the *"Forms"* tab to view a listing of all KEPRO fax forms, labeled by form number and service type.

Processing Requests at KEPRO:

KEPRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached KEPRO notifies the member and the provider in writing of the status of the request through the Medicaid Management Information System (MMIS) letter generation process.

If there is insufficient medical necessity information to make a final determination, KEPRO will pend the request back to the provider requesting additional information. If the information is not received within the time frame requested by KEPRO, the request will automatically be sent to a KEPRO physician for a final determination with all information that has been submitted. In the absence of clinical information, the request will be submitted to the KEPRO supervisor for review and final determination. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instructions on how to file an appeal is included in the MMIS generated letter.

If services cannot be approved for members under the age of 21 using the current criteria, KEPRO will then review the request by applying EPSDT criteria.

Review Criteria to be Used:

DMAS criteria for medical necessity will be considered if a service is covered under the State Plan and is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve functional disability. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the medical standard of practice. DMAS criteria may include CMS' Nationally Recognized Criteria (NRC). Therefore, all approvals must meet these agency criteria. All other criteria, including McKesson InterQual® or other McKesson review products, EPSDT, and physician review criteria are used for guidelines and reference purposes only.

McKesson InterQual®: KEPRO will apply McKesson InterQual® or other McKesson

product criteria to certain services and DMAS criteria where McKesson InterQual® products do not exist.

The VaMMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination.

DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individual's file, and are subject to review during Quality Management Review (QMR).

Direct all telephone inquiries regarding Service Authorization to the DMAS Provider Helpline at: 1-888-829-5373.

KEPRO does not review requests when members have Medicare Part B. If Medicare denies the requested stay, the provider may submit a request in writing for Srv Auth as a retrospective review. This must be submitted to KEPRO within 30 days of the notice of denial by Medicare. The justification for requesting retrospective review must be stated on the request.

Detailed documentation to address medical necessity, including discharge planning, must be submitted with each plan of care. KEPRO will review this information and determine if the request meets DMAS criteria for the initiation and continuation of care. Please refer to Chapter VI of this manual for documentation requirements.

How to Determine if Services Require Service Authorization

In order to determine if services need to be service authorized, providers should go to the DMAS website: http://dmasva.dmas.virginia.gov and look to the right of the page and click on the section that says Procedure Fee Files which will then bring you to this: http://www.dmas.virginia.gov/pr-fee_files.htm. You will now see a page entitled DMAS Procedure Fee Files. The information provided there will help to determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

To determine if a service needs Service Authorization, next determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version. The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the

following:

00 – No PA is required

01 – Always needs a PA

02 -Only needs PA if service limits are exceeded

03- Always need PA, with per frequency.

To determine whether a service is covered by DMAS you need to access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides you special coverage and/or payment information. A Procedure Flag of "999" indicates that a service is non-covered by DMAS.

Intensive Rehabilitation Services

Service Authorization for Intensive Rehabilitation Services

All requests for Service Authorization, as well as any information submitted in response to pend letters, must be directed to the DMAS Srv Auth contractor. The rehabilitation providers have the option of submitting Service Authorization requests either telephonically, on paper, by fax, or other means described by the Srv Auth contractor on their website, www.dmas.kepro.com. There may be circumstances where the provider will be required to submit written documentation in order to obtain Service Authorization. All requests for Service Authorization must be received through KEPRO within 72 hours of admission. Requests received after 72 hours will be denied up to the date the request is received. If the member continues to meet medical necessity criteria and is still in the facility, the request may be approved starting the day the request is received at KEPRO.

DMAS will conduct post payment review audits for intensive rehabilitation providers and will strongly enforce the 72-hour notification policy. Failure to comply may result in the retraction of payment. Srv Auth must be obtained whether Medicaid is the primary payer, except for Medicare-crossover claims. KEPRO will not accept reviews for members who have Medicare Part A. If Medicare denies the requested stay and/or if the Medicare benefits are exhausted**,** the provider may submit a Srv Auth request for retrospective review within 30 days of the notice of denial or exhaustion by Medicare. Retrospective reviews will be performed when a provider is notified of a patient's retroactive eligibility for Virginia Medicaid

coverage. Prior to billing Medicaid the provider must have a Srv Auth. The health care provider should request a Srv Auth for retrospective review within 30 days of the notice of Medicaid eligibility.

Within 72 hours of the Intensive Rehab admission, the provider must submit a request for Srv Auth to KEPRO. The review analyst will assign an initial length of stay. The provider must contact KEPRO prior to the Srv Auth end date if services are to extend beyond the initial authorization period.

CORF providers must submit service authorization requests under Srv Auth service type 0204 (Outpatient Rehab) using the appropriate NPI number.

If the provider fails to submit information for the continued stay and the authorization period expires, retroactive authorization will not be granted. Authorization will begin with the date the continued stay request is received at KEPRO.

KEPRO will apply *McKesson InterQual® Criteria, Rehabilitation, Adult & Pediatric* for determining medical necessity.

In addition, DMAS requires the following for Intensive Rehab Services:

- The member meets *McKesson InterQual® Criteria, Rehabilitation, Adult & Pediatric* criteria upon admission and continued stay. These criteria may be obtained through:

  McKesson Health Solutions LLC
  275 Grove Street

  Suite 1-110

  Newton, MA 02466-2273

  Telephone: 800-274-8374

  Fax: 617-273-3777

  Website: www.mckesson.com or www.InterQual.com

Outpatient Rehabilitation Services

Service Authorization for Outpatient Rehabilitation Services

Providers enrolled as “general hospital, in state” shall use the DMAS designated revenue codes when requesting service authorization.

All providers including outpatient rehabilitation agencies, comprehensive outpatient rehabilitation facilities (CORF), physicians and professionals shall use the DMAS designated CPT codes listed below.

Reference the chart below to determine the appropriate code to be used when requesting Srv Auth through KEPRO. The chart indicates the specific unit/visit equivalency.

In-state general hospital and in-state rehabilitation hospital providers (Provider Types 001,014) use DMAS approved revenue codes:	
0424	Physical Therapy, Evaluation
0421	Physical Therapy, Individual
0423	Physical Therapy, Group
0434	Occupational Therapy, Evaluation
0431	Occupational Therapy, Individual
0433	Occupational Therapy, Group
0444	Speech Language Services, Evaluation
0441	Speech Language Services, Individual
0443	Speech Language Services, Group
	1 unit = 1 visit for these revenue codes

In-state private rehabilitation agencies, CORFs, and physician providers (Provider Types 057,019,020, respectively) use DMAS approved CPT codes:	
97110	Therapeutic procedure, Physical Therapy, each 15 minutes. 1 unit = 15 minutes.
97150	Therapeutic procedure, Physical Therapy, Group. 1 unit = a group session
97161*	Physical Therapy evaluation: low complexity 1 unit = an evaluation
97162*	Physical Therapy evaluation: moderate complexity 1 unit = an evaluation
97163	Physical Therapy evaluation: high complexity 1 unit = an evaluation.

97530	Therapeutic procedure, Occupational Therapy, each 15 Minutes. 1 unit = 15 minutes.
S9129	Therapeutic procedure, Occupational Therapy, Group. 1 unit = a group session.
97165*	Occupational Therapy evaluation: low complexity 1 unit = an evaluation
97166*	Occupational Therapy evaluation: moderate complexity 1 unit = an evaluation
97167	Occupational Therapy evaluation: high complexity 1 unit = an evaluation.
92507	Treatment of speech, language, voice, communication, and / or auditory processing disorder; Individual. 1 unit = one treatment session
92508	Treatment of speech, language, voice, communication, and / or auditory processing disorder; Group, 2 or more individuals. 1 unit = one treatment session.

*For CPT Codes 97110 (PT) and 97530 (OT), when requesting a Service Authorization (Srv Auth) for these 2 codes, the units of time being requested should be based on the 15- minute interval and not based on a visit.

*Coverage for these codes is effective for dates of service on or after December 1, 2018.

Example: PT therapist has determined that a recipient needs to have an hour a day, three times a week for a total of four weeks of physical therapy. The Srv Auth request for PT would be for a total of 48 units (4 units per day times, 3 times a week, times 4 weeks = 48 units).

For non-hospital providers: Four (4) specific codes are utilized for speech therapy evaluation as follows:

92521	Evaluation of speech fluency (e.g. stuttering, cluttering)
92522	Evaluation of speech sound production (e.g. Articulation, phonological process, apraxia, dysarthria

92523	Evaluation of speech sound production (e.g. Articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g. Receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance

Note: 1 unit = 1 evaluation

When submitting srv auth requests, providers must select the most appropriate speech therapy evaluation code based on the physician's order and diagnosis. Providers may only use one code per member per date of service (DOS) for each srv auth request. When medically necessary, providers may submit the same or another speech therapy evaluation code using different dates of service (no duplicate dates or overlapping dates with previous srv auth request).

Example #1: Provider receives physician's order for speech therapy evaluation. Initial srv auth request submitted for 92521, 1 unit, for DOS 7/12/17. Evaluation not completed due to member's medical condition. Second request submitted (to complete evaluation) for 92521, 1 unit, for DOS 7/14/17.

Example #2: Initial srv auth request submitted for 92523, 1 unit, for DOS 7/12/17. Evaluation completed. New physician's order written as result of initial evaluation findings. Second request submitted for augmentative communication eval using 92522, 1 unit, for DOS 7/23/17.

For non-hospital (outpatient rehab) providers: Effective for dates of service on or after December 1, 2018, DMAS will provide coverage for all levels of PT and OT evaluation. The CPT codes are:

97161	Physical Therapy evaluation: low complexity 1 unit = an evaluation
97162	Physical Therapy evaluation: moderate complexity 1 unit = an evaluation
97163	Physical therapy evaluation: high complexity

97165	Occupational Therapy evaluation: low complexity 1 unit = an evaluation

97166	Occupational Therapy evaluation: moderate complexity 1 unit = an evaluation
97167	Occupational therapy evaluation: high complexity

Providers may only use one code per member per date of service (DOS) for each srv auth request. These codes are used for initial evaluations and for re-evaluations when another evaluation is medically necessary and/or a member has had a significant change in their medical condition. The evaluation codes are specific to Medicaid members for billing purposes.

Note: If a member has received an evaluation prior to 12/1/2018, providers should utilize CPT code 97163 or 97167 for the dates of service being requested.

Service Limitations

Physical therapy, occupational therapy, and speech-language pathology services shall be limited to five (5) visits per rehabilitative discipline annually without service authorization. Initial therapy evaluations are included in the 5 visits. (For definition of visits please reference chart above). Visits include those services provided by outpatient settings of acute and rehabilitation hospitals, nursing facilities, rehabilitation agencies, and home health agencies. Limits are specific per discipline and member, regardless of the number of providers rendering services. "Annually" is defined as July 1 through June 30. The provider must maintain documentation to justify the need for services. Srv Auth is required before payment will be made for any visits over annually.

Evaluations must be related to the admission or readmission to service or to a significant change in the condition of the member. For continued authorization beyond the initial period, providers must submit a request prior to the Srv Auth end date. Reimbursement shall not be made for additional services without Srv Auth. Care rendered beyond the 5th visit allowed annually which has not been authorized shall not be approved for reimbursement.

Srv Auth must be obtained whether or not Medicaid is the primary payer, except for Medicare-crossover claims. Srv Auth is required when more than 5 visits are medically necessary. When a member has Medicare Part B coverage, Srv Auth is not required. If Medicare denies the claim and/or if Medicare benefits are exhausted, the provider may request authorization as a retrospective review. Retrospective review will be performed when a provider is notified of a patient's retroactive eligibility for Virginia Medicaid coverage. Prior to billing Medicaid, the health care provider must request a retrospective service authorization.

Providers may obtain information regarding service limit utilization by contacting any of the following:

DMAS Provider HelpLine 1-800-552-8627 (in-state long distance)

1-804-786-6273 (local and out-of-state customers)

MediCall System 1-800-772-9996

1-800-884-9730

1-804-965-9732 (Richmond area)

Automated Response System (ARS):
www.virginiamedicaid.dmas.virginia.gov

Service Authorization Processing

Srv Auth for outpatient rehabilitation services must be obtained through KEPRO. All Srv Auth requests, as well as any information submitted in response to pend letters, must be directed to KEPRO. If the provider fails to submit information prior to the completion of the 5th visit, retroactive authorization will not be granted. Authorization will begin with the date the request is received at KEPRO. Any service provided without Srv Auth in excess of the 5th visit limitation will not be reimbursed.

Initial Review for Outpatient Rehab

When Srv Auth is requested before or at the initiation of services, the provider may use the physician's order. DMAS (or KEPRO) will make a decision to approve, pend, deny, or reject the request. If the request is approved, an authorization will be given for a specific number of units and dates of service. Visits provided up to and including the 5th visit, may be billed without Srv Auth if the member's service limits have not been used. Providers may contact ARS or MediCall for information on the service limits already provided to a member.

Recertification Review for Outpatient Rehab

Prior to the last Srv Auth end date, or the next visit, the provider must submit a

request for continued Srv Auth. This request will be reviewed to determine if DMAS criteria and documentation requirements are met. Documentation requirements are located in Chapter VI of this manual. A decision will be made to approve, pend, deny, or reject the request. Approvals will include a specific number of units and dates of service.

For Outpatient Rehab Services, DMAS requires the member meets *McKesson InterQual®, Outpatient Rehabilitation & Chiropractic* criteria upon initial and/or recertification review. These criteria may be obtained through:

McKesson Health Solutions LLC 275
Grove Street

Suite 1-110

Newton, MA 02466-2273

Telephone: 800-274-8374

Fax: 617-273-3777

Website: www.mckesson.com or www.InterQual.com

NOTE TO ALL OUTPATIENT REHAB PROVIDERS: On July 1st of each year, the 5 service limits/units per discipline for rehab agencies, CORFs, physicians, professionals and out of state providers and the 5 service limits/visits per discipline for general, in-state hospitals and out of state providers is renewed. If a provider knows that the member will need treatment beyond 5 visits, they must request Srv Auth through KEPRO.

Procedural Change for Service Authorization Requests for Outpatient Rehabilitation Services

As stated in the DMAS Memo dated June 3, 2015, providers are to submit a service authorization request to KEPRO for dates of service that cover the entire duration of the member's current plan of care, even if the dates of service span over the state's fiscal year (beginning July 1).

KEPRO's New Process:

- Providers who obtain a service authorization approval for outpatient rehabilitative services from KEPRO with dates of service spanning the state's fiscal year (July 1), may utilize this service authorization number for claims submission for all dates of service included in the authorization.
- The provider must utilize the member's initial five units in the state fiscal year (beginning July 1 annually) that do not require service authorization.
- After the five units have been utilized, the provider continues to use the service authorization number given by KEPRO for all dates of service provided after the initial five units have been utilized through the last date of service approved on the service authorization.
- Providers are responsible to bill DMAS correctly for the first five units that do not require service authorization. Service authorization is required before payment will be made for any units over five annually. Providers may contact the Provider Helpline to determine if the first five units are available.

Out-of-State Provider Information for Intensive and Outpatient Rehabilitation

The following information is the current policy and procedure for out of state requests submitted by out of state providers. This change impacts out of state providers who submit Virginia Medicaid service authorization requests to Keystone Peer Review Organization (KEPRO), DMAS' service authorization contractor, and any other entity to include, but not limited to, DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) when providing service authorizations for the services listed in the DMAS memo dated February 6, 2013 and titled *"Notification of a Procedural Change for Out of State Providers Submitting Requests for Service Authorization Through KePRO."*

KEPRO's service authorization process for certain services including Inpatient Intensive Rehabilitation will include determining if the submitting provider is considered an out of state provider. Out of state providers are defined as those providers that are either physically outside the borders of the Commonwealth of Virginia or do not provide year end cost settlement reports to DMAS. Please refer to the above referenced DMAS memo dated February 6, 2013 located on the Medicaid Web Portal for more information.

Out-of-State general hospital providers and out of state rehabilitation hospital providers may request these revenue codes:

0420	Physical Therapy (P.T.) - General; 1 unit = 1 visit
0430	Occupational Therapy (O.T.) - General; 1 unit = 1 visit
0440	Speech Language Pathology - General; 1 unit = 1 visit

Intensive Rehabilitation Information for Out-of-State Provider Requests

Out-of-state providers, located close to the proximity of the VA State line and who are enrolled with Virginia Medicaid as a **provider class type 085** (**Out of State Rehab Hospital**) need to determine and document evidence that one of the following items are met at the time the service authorization request is submitted to the service authorization contractor:

Services provided out of state for circumstances other than these specified reasons shall not be covered.

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is the general practice for recipients in a particular locality to use medical resources in another state.

The provider needs to determine which item 1 through 4 is satisfied at the time of the request to the Contractor. If the provider is unable to establish one of the four, the Contractor will:

- Pend the request utilizing established provider pend timeframes
- Have the provider research and support one of the items above and submit back to the Contractor their findings.

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52.

Outpatient Rehabilitation Information for Out-of-State Provider Requests

Authorization requests for certain services including Outpatient Rehabilitation agencies can be submitted by out of state providers. Procedures and/or services may be performed out of state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time

period.

Services provided out of state for circumstances other than these specified reasons shall not be covered:

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is the general practice for recipients in a particular locality to use medical resources in another state.

The provider needs to determine which item 1 through 4 is satisfied at the time of the request to the Contractor. If the provider is unable to establish one of the four, the Contractor will:

- Pend the request utilizing established provider pend timeframes
- Have the provider research and support one of the items above and submit back to the Contractor their findings

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52.

Early Periodic Screening Diagnosis and Treatment Service (EPSDT) Authorization

EPSDT is a Federal law (42 CFR § 441.50 et seq) which requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, and is composed of two parts:

1. EPSDT promotes the early and universal assessment of children’s healthcare needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. These services must be provided by Medicaid at no cost to the member.

2. EPSDT also compels state Medicaid agencies to cover other services,

products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" [make better] a defect, physical or mental illness, or condition [health problem] identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service for adults under the state plan. For more information, visit: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

All Medicaid and FAMIS Plus services that are currently service authorized by the Srv Auth contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, DMAS.KePRO.com. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX OR 1-877-652- 9329.

Examples of EPSDT Review Process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.
- Another example using mental health services would be as follows: A child has been routinely hitting her siblings; the child has received 20 individualized counseling sessions and 6 family therapy sessions to address this behavior. Because the behavior has decreased, but new problematic behaviors have developed such as nighttime elopement

and other dangerous physical activity, more therapy was requested for the child. The service limit was met for this service. But because there is clinical evidence from the therapy providers to continue treatment, the contractor should approve the request because there is clinically appropriate evidence which documents the need to continue therapy in a variation or continuation of the current treatment modalities.

The review process as described is to be applied across all non-waiver Medicaid programs for children. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program. Examples of non-covered services are inclusive of but are not limited to the following services: residential substance abuse treatment, behavioral therapy, specialized residential treatment not covered by the psychiatric services program. All service requests must be a service that is listed in (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).

Medicaid Expansion

On January 1, 2019 Medicaid expansion became effective. Individuals eligible for Medicaid expansion are:

- Adults ages 19-64,
- Not Medicare eligible,
- Not already eligible for a mandatory coverage group,
- Income from 0% - 138% Federal Poverty Level (FPL), and
- Individuals who are 100% - 138% FPL with insurance from the Marketplace. The new expansion aid categories:

Aid Category	Description
AC 100	Caretaker Adult, Less than or equal to 100% of the Federal Poverty Level (FPL) and greater than LIFC
AC 101	Caretaker Adult, Greater than 100% FPL
AC 102	Childless Adult, Less than 100% FPL

AC 103	Childless Adult, Greater than 100% FPL
AC 106	Presumptive Eligible Adults Less than or equal to 133% FPL
AC 108	Incarcerated Adults

The Medicaid Expansion Benefit Plan includes the following services:

Covered Service
Doctor, hospital and emergency room services
Prescription drugs
Laboratory and x-ray
Maternity and newborn care
Behavioral health services including addiction and recovery treatment
Rehabilitative and habilitative services including physical, occupational, and speech therapies and equipment
Family planning
Transportation to appointments
Home Health
DME and supplies
Long Term Support Services (LTSS) to include Nursing Facility, PACE and Home and
Community Based Service
Preventive and wellness
Chronic disease management
Premium assistance for the purchase of employer-sponsored health insurance coverage, if cost effective
Referrals for job training, education and job placement

All of the services currently submitted and reviewed by KEPRO remain the same. There are no new expansion benefits that require service authorization by KEPRO.

Telehealth Services Supplement

Definitions (TH)

Audio only

The use of real-time telephonic communication that does not include use of video.

Distant Site

The distant site is the location of the Provider rendering the covered service via telehealth.

Originating Site

The originating site is the location of the member at the time the service is rendered, or the site where the asynchronous store-and-forward service originates (i.e., where the data are collected). Examples of originating sites include: medical care facility; Provider's outpatient office; the member's residence or school; or other community location (e.g., place of employment).

Provider

For purposes of this manual supplement, the term "Provider" refers to the billing provider – either a qualified, licensed practitioner of the healing arts or a facility – who is enrolled with DMAS.

Remote Patient Monitoring

Remote Patient Monitoring (RPM) involves the collection and transmission of personal health information from a beneficiary in one location to a provider in a different location for the purposes of monitoring and management. This includes monitoring of both patient physiologic and therapeutic data.

Store-and-Forward

Store-and-forward means the asynchronous transmission of a member's medical information from an originating site to a health care Provider located at a distant site. A member's medical information may include, but is not limited to, video clips, still images, x-rays, laboratory results, audio clips, and text. The information is reviewed at the Distant Site without the patient present with interpretation or results relayed by the distant site Provider via synchronous or asynchronous communications.

Telehealth

Telehealth means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices. Telehealth includes services delivered in the dental health setting (i.e., teledentistry), and telehealth policies for dentistry are covered in the dental manuals.

Telemedicine

Telemedicine is a means of providing services through the use of two-way, real time interactive electronic communication between the member and the Provider located at a site distant from the member. This electronic communication must include, at a minimum,

the use of audio and video equipment. Telemedicine does not include an audio-only telephone.

Virtual Check-In

A Virtual Check-In is a brief patient-initiated asynchronous or synchronous communication and technology-based service intended to be used to decide whether an office visit or other service is needed.

Reimbursable Telehealth Services

Attachment A lists covered services that may be reimbursed when provided via telehealth. Specifically:

Table 1 –

- Table 3 list Telemedicine and Store-and-Forward services
- Table 4 lists Remote Patient Monitoring services
- Table 5 lists Virtual Check-In services
- Table 6 lists audio only services

Services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

- The Provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth;
- The service delivered via telehealth meets the procedural definition and components of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as defined by the American Medical Association (AMA), unless otherwise noted in Table 1 – Table 6 in this Supplement;
- The service provided via telehealth meets all state and federal laws regarding confidentiality of health care information and a patient's right to his or her medical information;
- Services delivered via telehealth meet all applicable state laws, regulations and licensure requirements on the practice of telehealth; and
- DMAS deems the service eligible for delivery via telehealth.

In order to be reimbursed for services using telehealth that are provided to Managed Care

Organization (MCO)-enrolled individuals, Providers must follow their respective contract with the MCO. Additional information about the Medicaid MCO programs can be found at https://www.dmas.virginia.gov/#/cccplus and https://www.dmas.virginia.gov/#/med4.

Additional modality-specific conditions for reimbursement are provided, below.

Telemedicine

- Services delivered via telemedicine must be provided with the same standard of care as services provided in person.

- Telemedicine must not be used when in-person services are medically and/or clinically necessary. The distant Provider is responsible for determining that the service meets all requirements and standards of care. Certain types of services that would not be expected to be appropriately delivered via telemedicine include, but are not limited to, those that: are performed in an operating room or while the patient is under anesthesia; require direct visualization or instrumentation of bodily structures; involve sampling of tissue or insertion/removal of medical devices; and/or otherwise require the in-person presence of the patient for any reason.

- If, after initiating a telemedicine visit, the telemedicine modality is found to be medically and/or clinically inappropriate, or otherwise can no longer meet the requirements stipulated in the "Reimbursable Telehealth Services" section, the Provider shall provide or arrange, in a timely manner, an alternative to meet the needs of the individual (e.g., services delivered in-person; services delivered via telemedicine when conditions allow telemedicine to meet requirements stipulated in the "Reimbursable Telehealth Services" section). In this circumstance, the Provider shall be reimbursed only for services successfully delivered.

Remote Patient Monitoring

- The Provider must have an established relationship with the member receiving the RPM service, including at least one visit in the last 12 months (which can include the date RPM services are initiated).
- The member receiving the RPM service must fall into one of the following five populations, with duration of initial service authorization in parentheses as per below:
    - Medically complex patient under 21 years of age (6 months);
    - Transplant patient (6 months);
    - Post-surgical patient (up to 3 months following the date of surgery);
    - Patient with a chronic health condition who has had two or more hospitalizations or emergency department visits related to such chronic health condition in the previous 12 months (6 months); and/or a
    - High-risk pregnant person (6 months).
- All service authorization criteria outlined in the DMAS Form "DMAS-P268" are met

prior to billing the following CPT/HCPCS codes:
    - Physiologic Monitoring: 99453, 99454, 99457, 99458, and 99091
    - Therapeutic Monitoring: 98975, 98976, 98977, 98980, and 98981
    - Self-Measured Blood Pressure: 99473, 99474
- Providers must meet the criteria outlined in the DMAS Form "DMAS-P268" and submit their requests to the DMAS service authorization contractor by direct data entry (DDE) via their provider portal. See Appendix D of the *Physician/Practitioner* manual for details on the current service authorization contractor and accessing the provider portal.
- Service authorization requests must be submitted at least 30 days prior to the scheduled date of initiation of services.
- Reauthorizations will be permitted for select services, as appropriate and as per criteria in the DMAS Form "DMAS-P268".

Virtual Check-In

- Services must be patient-initiated.
- Patients must be established with the provider practice.
- Must not be billed if services originated from a related service provided within the previous 7 days or lead to a service or procedure within the next 24 hours or at the soonest available appointment.

Reimbursement and Billing for Telehealth Services

Telemedicine

Distant site Providers must include the modifier **GT** on claims for services delivered via telemedicine.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location in which a telehealth service would *have normally been provided*, had interactions occurred in-person. For example, if the member would have come to a private office to receive the service outside of a telehealth modality, a POS 11 would be applied. Providers should **not** use POS 02 on telehealth claims, even though this POS is referred to as "telehealth" for other payers. Place of service codes can be found at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

Store-and-Forward

Distant site Providers must include the modifier **GQ**.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting,

should reflect the location where the distant site provider is located at the time that the service is rendered.

Remote Patient Monitoring

No billing modifier is required on claims for services delivered via RPM.

Devices used to satisfy conditions for CPT 99453 and 99454 must automatically digitally upload patient data (i.e., not self-recorded or reported by patients) and automatically transmit either daily recordings of the beneficiary's physiologic data OR the device must record daily values and transmit an alert if the beneficiary's values fall outside predetermined parameters for 16 days in a 30-day period. Devices used to satisfy conditions for CPT 98975, 98976 and 98977 must be used to monitor data for 16 days in a 30-day period. These codes cannot be used for monitoring of parameters for which more specific codes are available (i.e., CPT 93296, 93264, 94760).

Services billed for using CPT 99457, 99458 and 99091 may involve review of data collected in conjunction with codes CPT 99453, 99454, or physiologic data manually captured and submitted by the patient/caregiver for billing providers to review. Services billed for using CPT 98980 and 98981 may involve review of data collected in conjunction with codes 98975, 98976, 98977, or therapeutic data (including self-reported data) manually captured and submitted by the patient/caregiver for billing providers to review.

Time requirements associated with CPT 99457, 99458, 98980, 98981, and 99091 can include time spent furnishing care management services, if not billed for under other reported services, as well as time spent on required direct interactive communication. Interactive communication is defined as real-time synchronous, two-way audio interaction. Time spent on a day when the billing provider reports an E/M service (office or other outpatient services) shall not be included. Time counted toward time requirements of other reported services must also not be counted toward the time requirements of the aforementioned codes.

Only providers eligible to bill CMS Evaluation & Management (E&M) services are eligible to bill for RPM services. Clinical staff members—who work under the supervision of the eligible billing provider and are allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who do not individually report that professional service—are allowed to assist in delivery and satisfaction of

appropriate RPM service requirements for 99453, 98975, 99457, 99458, 98980, and 98981, but not 99091.

Codes including the provision of RPM devices (99454, 98976, 98977) shall not be billed if patients supply their own device, or have been separately provided relevant durable medical equipment by DMAS.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, shall reflect the location in which patients would *normally be evaluated*. For example, if the member would have come to a private office to discuss management of the condition being monitored via RPM, a POS 11 would be applied. Providers should not use POS 02 on telehealth claims, even though this POS is referred to as "telehealth" for other payers. Place of service codes can be found at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

An individual provider must not bill for more than one set of RPM services per patient at any given time.

Virtual Check-In

No billing modifier is required on claims for the covered Virtual Check-In codes listed, in Table 5 of Attachment A.

Virtual Check-In services do not require service authorization.

Only physicians and other qualified health care professionals – previously defined by the American Medical Association as being an individual who by education, training, licensure/regulation, and facility privileging (when applicable) performs a professional service within his/her scope of practice and independently reports a professional service – may furnish and bill for Virtual Check-In services.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location in which patients would have received services had the service occurred in-person and not virtually. For example, if the member would have come to a private office to discuss management of the condition being addressed via virtual check-in, a POS 11 would be applied. Providers should **not** use POS 02 on telehealth claims, even

though this POS is referred to as “telehealth” for other payers. Place of service codes can be found at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

Originating Site Fee (TH)

Telemedicine

In the event it is medically necessary for a Provider to be present at the originating site at the time a synchronous telehealth service is delivered, said Provider may bill an originating site fee (via procedure code Q3014) when the following conditions are met:

- The Medicaid member is located at a provider office or other location where services can be received (this does not include the member’s residence);
- The member and distant site Provider are not located in the same location; and
- The Provider (or the Provider’s designee), is affiliated with the provider office or other location where the Medicaid member is located and attends the encounter with the member. The Provider or designee may be present to assist with initiation of the visit but the presence of the Provider or designee in the actual visit shall be determined by a balance of clinical need and member preference or desire for confidentiality.

All telehealth modalities

Originating site Providers, such as hospitals and nursing homes, submitting UB-04/CMS-1450 claim forms, must include the appropriate telemedicine revenue code of 0780 (“Telemedicine-General”) or 0789 (“Telemedicine-Other”). The use of these codes is currently not applicable for services administered by Magellan of Virginia.

Telehealth services may be included in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Center (IHC) scope of practice, as approved by HRSA and the Commonwealth. If approved, these facilities may serve as the Provider or originating site and bill under the encounter rate. The encounter rate methodology for FQHCs and RHCs is described in 12VAC30-80-25; the encounter rate for IHCs (including Tribal clinics) is the All Inclusive Rate set by Indian Health Services.

Service Limitations (TH)

Unless otherwise noted in Attachment A, limitations for services delivered via telehealth are the same as for those delivered in-person.

Provider Requirements (TH)

All coverage requirements for a particular covered service described in the DMAS Provider Manuals apply regardless of whether the service is delivered via telehealth or in-person.

Providers must maintain a practice at a physical location in the Commonwealth or be able to make appropriate referral of patients to a Provider located in the Commonwealth in order to ensure an in-person examination of the patient when required by the standard of care.

Providers must meet state licensure, registration or certification requirements per their regulatory board with the Virginia Department of Health Professions to provide services to Virginia residents via telemedicine. Providers shall contact DMAS Provider Enrollment (888-829-5373) or the Medicaid MCOs for more information.

Documentation Requirements (TH)

Providers delivering services via telehealth must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes. Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. The distant site Provider can bill for covered benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. This documentation should be maintained in the patient’s medical record.

When billing for an originating site, the originating site and distant site Providers must maintain documentation at the originating Provider site and the distant Provider site respectively to substantiate the services provided by each. When the originating site is the member’s residence or other location that cannot bill for an originating site fee, this requirement only applies to documentation at the distant site.

Utilization reviews of enrolled Providers are conducted by DMAS, the designated contractor or the Medicaid MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the Provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified. Providers should be aware that findings during a utilization review that support failure to appropriately bill for telemedicine services as defined in this policy manual, including use of the GT/GQ modifier, appropriate POS or accurate procedure codes are subject to retractions.

Member Choice and Education (TH)

Before providing a telehealth service to a member, the Provider shall inform the patient about the use of telehealth and document verbal, electronic or written consent from the patient or legally-authorized representative, for the use of telehealth as an acceptable mode

of delivering health care services. This documented consent shall be maintained in the medical record. When obtaining consent, the Provider must provide at least the following information:

- A description of the telehealth service(s);
- That the use of telehealth services is voluntary and that the member may refuse the telehealth service(s) at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of the member's benefits;
- That dissemination, storage, or retention of an identifiable member image or other information from the telehealth service(s) shall comply with federal laws and regulations and Virginia state laws and regulations requiring individual health care data confidentiality;
- That the member has the right to be informed of the parties who will be present at the distant (Provider) site and the originating (member) site during any telemedicine service and has the right to exclude anyone from either site; and
- That the member has the right to object to the videotaping or other recording of a telehealth consultation.

If a Provider, whether at the originating site or distant site, maintains a consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services including the information noted above, this shall meet DMAS's required documentation of patient consent.

Telehealth Equipment and Technology

Equipment utilized for telemedicine must be of sufficient audio quality and visual clarity as to be functionally equivalent to in-person encounter for professional medical services.

Equipment utilized for Remote Patient Monitoring must meet the Food and Drug Administration (FDA) definition of a medical device as described in section 201(h) of the Federal, Food, Drug and Cosmetic Act.

Providers must be proficient in the operation and use of any telehealth equipment.

Telehealth encounters must be conducted in a confidential manner, and any information sharing must be consistent with applicable federal and state laws and regulations and

DMAS policy. Health Information Portability and Accountability Act of 1996 (HIPAA) confidentiality requirements are applicable to telemedicine encounters.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under HIPAA. Providers shall follow OCR HIPAA rules with the member, including services provided via telehealth. Providers are responsible for ensuring distant communication technologies meet the requirements of the HIPAA rules.

Attachment A (TH)

Clinicians shall use their clinical judgment to determine the appropriateness of service delivery via telehealth considering the needs and presentation of each individual.

Table 1. Medicaid-covered medical services authorized for delivery by telemedicine*

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Colposcopy		• 57452, 57454, 57455, 57456, 57460, 57461
Fetal Non-Stress Test		• 59025
Prenatal and Postpartum Visits	• Synchronous audio-visual delivery is permissible for the prenatal and postpartum services stipulated in CPT 59400, 59410, 59510 and 59515; delivery services for those codes must be completed in person. • Providers should complete at least one in-person visit per trimester for which they bill prenatal services for the purposes of appropriate evaluation, testing, and assessment of risk.	• 59400, 59410, 59425, 59426, 59430, 59510, 59515
Radiology and Radiology-related Procedures		• 70010-79999 and radiology related procedures as covered by DMAS; GQ modifier if store and forward**
Obstetric Ultrasound		• 76801, 76802, 76805, 76810, 76811-76817
Echocardiography, Fetal		• 76825, 76826
End Stage Renal Disease		• 90951 - 90970
Remote Fundoscopy		• 92250; TC if applicable; GQ modifier if store and forward • 92227, 92228; 26 if applicable; GQ modifier if store and forward
Speech Language Therapy/Audiology		• 92507†, 92508†, 92521, 92522, 92523, 92524
Diagnosis, analysis cochlear implant function		• 92601-92604, 95974
Cardiography interpretation and report		• 93010
Echocardiography		• 93307, 93308, 93320, 93321, 93325
Genetic Counseling		• 96040
Maternal Mental Health Screening		• 96127, 96160††, 96161††

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Physical therapy / Occupational therapy		• 97110†, 97112†, 97150† • 97530†, S9129†
Medical Nutrition Therapy		• 97804
Evaluation & Management (Office/Outpatient)		• 99202-99205, 99211-99215; GQ modifier if teledermatology and store and forward
Evaluation & Management (Hospital)		• 99221-99223, 99231-99233; GQ modifier if teledermatology and store and forward
Evaluation & Management (Nursing facility)		• 99304-99306 • 99307-99310
Discharge planning (Nursing facility)		• 99315, 993169
Evaluation & Management (Assisted living facility)		• 99334, 99335, 99336
Respiratory therapy	• Must have respiratory equipment set up in home and initial in-person visit by a respiratory therapist or member of the clinical team. Restricted to outpatient respiratory therapy.	• 99503, 94664
Education for Diabetes, Smoking, Diet		• G0108, 97802, 97803
Early Intervention	• Must have family member/caregiver, service coordinator, or member of the clinical team physically present with member during visit. • Initial assessment (T1023) must be in-person with each assessing member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery. • Initial service visit (G* codes) must be in-person with a member of the clinical team physically present with member, except in cases of documented exceptional circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery.	• T2022 • w/ or w/o U1: T1023, T1024, T1027, G0151, G0152, G0153, G0495

Table 2. Medicaid-covered mental health and substance use disorder services authorized for delivery by telemedicine

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Diagnostic Evaluations		• 90791-90792
Psychotherapy		• 90832, 90834, 90837
Psychotherapy for Crisis		• 90839-90840
Pharmacologic counseling		• 90863
Psychotherapy w/ E&M svc		• 90833, 90836, 90838
Psychoanalysis		• 90845

Service(s)	Telemedicine-specific Service Limitations	Code(s)
Family/Couples Psychotherapy		• 90846-90847
Group Psychotherapy		• 90853
Prolonged Service, in office or outpatient setting		• 99354-99357
Psychological testing evaluation		• 96130, 96131
Neuropsychological testing evaluation		• 96132, 96133
Psychological or neuropsychological test administration & scoring		• 96136, 96137, 96138, 96139, 96146
Neurobehavioral Status Exam		• 96116, 96121
Add-on Interactive Complexity		• 90785
Health Behavior Assessment		• 96156
Health Behavior Intervention (Individual, group, family)		• 96158-96159 • 96164-96165 • 96167-96168 • 96170-96171
Evaluation & Management (Outpatient)		• 99202-99205, 99211-99215
Evaluation & Management (Inpatient)		• 99221-99223, 99231-99233
Smoking and tobacco cessation counseling		• 99406-99407
Alcohol/SA structured screening and brief intervention		• 99408-99409
OTP/OBOT Specific Services		• H0004, H0005, H0014*, G9012
SUD Case Management		• H0006
Mental Health Case Management Services		• H0023
IACCT Initial Assessment		• 90889 HK
IACCT Follow-Up Assessment		• 90889 TS
Mental Health Skill Building		• H0046
Crisis Stabilization		• H2019 (ended 11/30/2021)
Crisis Intervention		• H0036 (ended 11/30/2021)
Mobile Crisis Response	Telemedicine-assisted assessment only (See Appendix G to the Mental Health Services Manual)	• H2011 (effective 12/1/2021)
Community Stabilization	Telemedicine-assisted assessment only (See Appendix G to the Mental Health Services Manual)	• S9482 (effective 12/1/2021)
23 Hour Residential Crisis Stabilization	Psychiatric evaluation only (See Appendix G to the Mental Health Services Manual)	• S9485 (effective 12/1/2021)
Residential Crisis Stabilization	Psychiatric evaluation only (See Appendix G to the Mental Health Services Manual)	• H2018 (effective 12/1/2021)
Assertive Community Treatment		• H0040
Psychosocial Rehabilitation		• H2017
Intensive In-Home Services		• H2012
Therapeutic Day Treatment		• H2016
Behavioral Therapy Program		• H2033 (ended 11/30/2021)
Applied Behavior Analysis (ABA)	97151 and 97152 may be provided through telemedicine for reassessments only.	• 97151-97158 (effective 12/1/2021)
Multisystemic Therapy (MST)		• H2033 (effective 12/1/2021)
Functional Family Therapy (FFT)		• H0036 (effective 12/1/2021)
Foster Care Case Management		• T1016
Peer Recovery Support Services (PRSS)		• H0024, H0025, S9445, T1012
Mental Health Partial Hospitalization Program		• H0035
Mental Health Intensive Outpatient Program		• S9480
SUD Partial Hospitalization Program		• S0201

Service(s)	Telemedicine-specific Service Limitations	Code(s)
SUD Intensive Outpatient Program		• H0015

Table 3. Radiology-Related Procedures for Physician Billing Included under Telehealth Coverage

Procedure Title (Reduced Length)	CPT Code
Fine needle aspiration; with imaging guidance	10022
Biopsy of breast; percutaneous, needle core, using image guidance	19102
Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device	19103
Preoperative placement of needle localization wire, breast	19290
Image guided placement, metallic localization clip, percutaneous, breast biopsy/aspiration	19295
Arthrocentesis, aspiration, and/or injection; major joint or bursa	20610
Transcatheter occlusion or embolization (eg, for tumor destruction, other)	37204
Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stage	47011
Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	49083
Electrocardiogram, routine ecg with at least 12 leads; with interpretation	93000
Electrocardiogram, routine ecg with at least 12 leads; interpretation and report only	93010
Echocardiography, transthoracic, real-time with image documentation (2d)	93306
Duplex scan of extremity veins including responses to compression and other	93970
Duplex scan of extremity veins including responses to compression and other	93971
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs	93975
Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, other organs	93976

Table 4. Medicaid-covered services authorized for delivery via Remote Patient Monitoring

Procedure Title (Reduced Length)	Code
Collection & interpretation of physiologic data digitally stored/transmitted 30 min per 30d	99091
Remote monitoring of physiologic parameter(s); set-up and education on use of equipment	99453

Remote monitoring of physiologic parameter(s); device(s) supply & daily recording(s) or programmed alert(s) transmission, each 30 days	99454
Remote physiologic monitoring treatment management services; interactive communication with the patient/caregiver during the month; first 20 minutes	99457
Each additional 20 minutes	99458
Remote therapeutic; initial set-up and patient education on use of equipment	98975
Respiratory system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days	98976
Musculoskeletal system device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission, each 30 days	98977
Remote therapeutic monitoring treatment management services; interactive communication with the patient or caregiver during the calendar month; first 20 minutes	98980
Each additional 20 minutes	98981
Self-measured blood pressure; patient education/training and device calibration	99473
Self-measured blood pressure; reported 2x daily for 30d w/ clinician review and communication of treatment plan	99474

Table 5. Virtual Check-In Services

Service	Code
Virtual check-in, E&M-eligible providers, 5-10 min	G2012
Virtual check-in, non-E&M-eligible providers, 5-10 min	G2251
Virtual check-in, E&M-eligible providers, 11-20 min	G2252
Remote evaluation of recorded video and/or images, E&M-eligible providers	G2010
Remote evaluation of recorded video and/or images, non-E&M-eligible providers	G2250

Table 6. Audio Only Services*

Service	Code
Telephone evaluation and management service provided by a physician; 5-10 minutes of medical discussion	99441
Telephone evaluation and management service provided by a physician; 11-20 minutes of medical discussion	99442
Telephone evaluation and management service provided by a physician; 21-30 minutes of medical discussion	99443
Telephone assessment and management service provided by a qualified nonphysician health care professional; 5-10 minutes of medical discussion	98966

Telephone assessment and management service provided by a qualified nonphysician health care professional; 11-20 minutes of medical discussion	98967
Telephone assessment and management service provided by a qualified nonphysician health care professional; 21-30 minutes of medical discussion	98968

* All fee-for-service claims for audio only codes should be billed directly to DMAS, including those delivered in the context of mental health and substance use disorder services. See Chapter V of the Physician/Practitioner Manual for detailed billing instructions.